8-1-1996

Mental Health Values of Native American College Students on Three Different Reservations

Raymond List

MENTAL HEALTH VALUES OF NATIVE AMERICAN COLLEGE STUDENTS ON THREE DIFFERENT RESERVATIONS

by

RAYMOND LIST

Master of Arts, University of North Dakota, 1992

A Dissertation

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Doctorate of Philosophy

Grand Forks, North Dakota

August 26, 1996

This dissertation, submitted by Raymond C. List in partial fulfillment of the requirements for the degree of Doctorate of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

(Chairperson)

This dissertation meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.

(Dean of the Graduate School) 9-26-96

PERMISSION

Title An Examination of the Mental Health Values of Native American College Students on Three Different Reservations: A Comparative Study

Department Psychology

Degree Doctorate of Philosophy

In presenting this dissertation in partial fulfillment of the requirements for a graduate degree from the University of North Dakota, I agree that the library of this University shall make it freely available for inspection. I further agree that permission for extensive copying for scholarly purposes may be granted by the professor who supervised my dissertation work or, in his absence, by the Chairperson of the department or the Dean of the Graduate School. It is understood that any copying or publication or other use of this thesis or part thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University of North Dakota in any scholarly use which may be made of any material in my thesis.

Signature Raymond Lin

Date 8/26/96

TABLE OF CONTENTS

LIST OF TABLES

ACKNOWLEDGEMENTS

I would especially like to thank the Native American people who gave their assistance and shared their thoughts and feelings with me.

My gratitude and appreciation also goes to the Marian College Psychology Department. Their dedication, support, and gentle demand for excellence has enabled me to reach this point.

ABSTRACT

This study was undertaken to add to knowledge about Native American perspective on mental health issues. The present investigation explored two questions. The first used the Mental Health Values Questionnaire to explore how Native American mental health values are connected to daily lifestyle patterns. The MHVQ is a 99-item instrument which yields scores for eight dimensions for conceptualizing healthy emotional adjustment (Tyler, Clark, Olson, Klapp, & Cheloha, 1983). The second question had to do with who Native Americans perceive to be appropriate sources of help for different types of perceived problems. This question was explored with the Sources of Referral Questionnaire (Tyler & Suan, 1989).

Subjects consisted of 98 college students from three different reservation based colleges. Degree of traditionality was assessed for each subject. The relationship between tribal differences, gender, and differences in traditionality on the scales of the MHVQ and the Sources of Referral Questionnaire were analyzed.

In order to compare the mental health values of Native Americans and Caucasians, a sample of 81 Caucasian subjects were chosen from a Northern Plains University. The responses from the two samples were compared for the MHVQ and the Sources of

Referral Questionnaire. Traditional spirituality of the Caucasian subjects was also assessed.

The results supported observations from the literature review that healthy interrelationships and receptivity to spiritual experiences were perceived by the Native American sample to be important for mental well-being. The results also demonstrated that variations in the perception of mental health and problem situations were associated with tribal membership, traditionality and gender. Guidelines for mental health strategies and suggestions for future research were discussed.

CHAPTER I

INTRODUCTION

Overview of Native American Values

In designing and implementing mental health programs for Native American communities, it is important to first develop an understanding of the traditional values of the community. Trimble, et al. (1984) propose that these traditional values help to define and shape the community's conception of "mental health" or well-being. Guilmet and Whited (1987) believe that mental health programs that are designed and implemented in the absence of awareness of these values could lead to more harm than healing. Similarly, Lafromboise (1988) argues that the traditional values and practices of the community should be incorporated into any mental health programs. Sensitivity and awareness would also appear to be important in forming strong bonds with the Native American community. In fact, traditional Native American clients appear to prefer professionals who are more culturally aware. McDonald (1991) in a survey of adult Native American outpatients and inpatients, found that more traditional Native American patients preferred therapists with knowledge of the local Native American culture. The desirability of such knowledge is further supported by the results from a survey of Native American parents in New Mexico whose children were

receiving services at IHS facilities (Malach & Segel, 1990). The authors report that parents desired more culturally appropriate services in order to increase understanding between themselves and the health professionals. The parents also requested that the professionals become more aware of how their culture views certain professional practices.

What, then, are these values of the Native American communities? It is important to first understand that the Native American population is not a homogeneous group. Native American tribes tend to vary in terms of specific beliefs and behavioral norms, along with geographical location, and societal structure (Shore & Manson, 1981). However, various observations and empirical findings in the literature have suggested some traditional values that appear to be fairly consistent across Native American communities. It is also important to remember, as these traditional values are reviewed, that Native American individuals presently vary in the degree to which they follow these traditional values.

Based upon her work among a number of Canadian tribes, Brant (1990) described her observations of the traditional values held to be important among various native communities. She observed that historically, group survival depended strongly on harmonious interpersonal relationships and cooperation. According to her observations, this tradition is observed among contemporary Native Americans in their avoidance of conflict in order to maintain harmony among the tribe. It can also be observed in their reluctance under certain circumstances to compete with one another as

individuals in order to promote cooperation. Noninterference is also a strong value among the people Brant worked with. For example, coercing another individual into an activity or forcing an opinion or decision on another person is viewed as disrespectful to that individual and as harmful to the harmony among the people. Emotional restraint, especially of anger, is also strongly encouraged as another way to maintain group harmony. As part of the emphasis on cooperation, sharing of one's material goods, instead of saving only for oneself is also encouraged. Brant (1990) also observed that the native concept of time is slightly different in that schedules are often changed to fit individuals instead of visa versa out of respect for the people. In general some of the basic traditional values, according to Brant (1990), appear to be emphasis on maintaining harmony among tribal members through cooperation instead of competition, sharing with each other, and respect for the individual.

Sue & Sue (1990) also report observing similar traditional values among Native American populations. They state that, traditionally, the tribe and the extended family formed the basis of the individual's identity. Each individual saw himself/herself as an extension of the tribe in that the tribe provided the individual with a sense of belonging and security through a system of interdependent relationships. An important part of this system, according to Sue & Sue, is the extended family network, which currently often extends to the second cousin. They observed that the values inherent in the traditional tribal system, many of which are similar to the ones observed by Brant (1990), continue to operate in modern times.

Among these values, Sue and Sue (1990) report, is sharing. Unlike in the urban-industrial society, status among the native community is gained through sharing material goods with others instead of through gathering things for oneself only. Sue and Sue further assert that cooperation, instead of competition, is also highly valued as a means to maintain harmony among the tribal members. Noninterference is also important in that individuals are taught to observe and speak sparingly rather than reacting impulsively to others' actions. Sue and Sue have found that the focus on maintaining the relationships with others also influences the Native American's attitude towards time in that being involved with what is currently happening and with the people in the present is sometimes more important than maintaining a rigid schedule. Finally, Sue and Sue state, maintaining harmony not only with the people, but also with the natural and spiritual world is considered to be a vitally important aspect of good living. This is done through prayer ceremonies, communication with spirits, and visions (Bearcomesout, 1993). Maintaining this bond with the spiritual realm is viewed as important to the maintainence of the emotional and physical well-being of both the community and the individual (Bearcomesout, 1993).

Heinrich, Corbine, & Thomas (1990) in their experiences with Native American communities observed traditional values similar to the ones described by the previous authors. They summarize their observations, as well as those of the previous authors, by proposing that the two most important traditional values, for many Native American communities, appear to be maintaining group and family

relationships through cooperation and sharing and demonstrating respect for the individual. They further describe how these basic values are carried over into the holistic view of helath and illness in many Native American communities. Since relationships with others and with one's physical and spiritual surroundings are held to be so important for everyday functioning, maintaining harmony with others and with one's surroundings is viewed as an essential aspect of well-being. Illness, therefore, is viewed as a disruption or imbalance in the harmony of the individual's relationships with the people, the environment, and the spirits around him/her. In order to better understand this view of illness, Heinrich, Corbine, & Thomas (1990) suggest that mental health professionals need to identify specific categories of illness and dysfunction within the community, the meaning that the community attributes to various symptoms, and the ways that the community explains health and illness.

Native American Concepts of Well-being and Illness

As part of this examination of the traditional concept of well-being and illness in many Native American communities, Trimble, et. al. (1984) first describe their observations of the essential differences between the European world view, upon which the US health care system, including mental health, is based, and the traditional world view in many Native American communities. Trimble, et. al. (1984) describe the concept of "mental health" in the European tradition as essentially an evaluative concept that refers to a particular state of well-being as well as the individual's ability to assess that state. It is particularly evaluative in that the awareness

of this state comes through another's inquires into the individual's well-being or through the individual's own attempts at achieving awareness of this state. The mental health concept is also part of the European biomedical tradition which assumes that something within the individual is out of balance. Therefore the professional needs to probe in order to bring about awareness of the imbalance. An important aspect of this assumption is that the individual and environment are separate and that the focus of the problem and solution is the individual.

However, according to Trimble, et. al. (1984), these assumptions of the European tradition which form the basis of the "mental health" concept conflict with the traditional world view of many Native American communities and may serve to alienate traditional Native American clients. In fact, Trimble, et. al. (1984) concluded from a review of the literature that many Native American clients leave therapy early out of dissatisfaction with the process, as a result of the different world views. Trimble, et. al. (1984) point out, that one of the biggest sources of conflict is the European biomedical tradition of separating the individual and the environment. This is a foreign concept to many Native American communities since for most Native American traditions the individual, the family, and the community are interrelated and inseparable. Furthermore, Trimble, et. al. (1984) state that since many of the terms and concepts within the European mental health tradition are based on this separation, they do not easily translate into the traditional Native American culture.

Another major conflict between world views, according to Trimble, et. al. (1984), is the European emphasis on probing into the individual's "inner being" in order to bring about insight and self-awareness. Such probing may not be considered appropriate in many Native American communities. For example, the authors point out that in the Lakota language, "mental health" most closely translates into ta-un. This refers to "being in a state of well-being, ...a state that allows a certain kind of behavior to occur" (Trimble, Manson, Dinges, & Medicine,1984 ,p. 201). Ta-un of an individual is rarely questioned and it is even considered rude in some areas to inquire about an individual's ta-un. They further point out that in many Native American communities, self-revelation is not encouraged outside of a very few private ceremonies. Therefore, the emphasis of many mental health interventions on probing for more insight could be considered inappropriate, rude and a violation of the value of respect for the individual (Heinrich, Corbine, & Thomas, 1990).

Trimble, et. al. (1984) conclude from these observations that the concept of "mental health" or well-being is formulated according to the values and belief system of the culture in which it is grounded. Therefore it is important to more closely examine different traditional Native American categories of illness in order to better realize the ways that different cultural values can influence the interpretation of different symptoms. For example, Trimble, et. al. (1984) examine the Windigo psychosis, which originates from the folktales of the Ojibwa and Cree of Canada. The symptoms include

melancholia, craving for human flesh, and the delusion of being transformed into a witiko who has a heart of ice and vomits ice. A review of the literature by Trimble, et. al. (1984), demonstrates Anglo-American attempts at fitting the disorder into the European traditional framework. They point out that the psychoanalytic writers interpret the disorder as symptomatic of failing ego defenses with the behavior as an expression of conflicting dependency and aggressive needs. These writers state that even though conscious content of the illness, i.e. the craving for human flesh and witiko delusion, is derived from cultural beliefs and traditions, the essential feature of the disorder is similar to those seen elsewhere (Kiev, 1972; Parker, 1960; Teicher, 1960). Trimble, et. al. (1984) describe another writer (Marano, 1982) who criticizes these explanations as being invalid since they are based on poor knowledge of culture as well lack of direct observation.

Another disorder described by Trimble, et. al. (1984), Pibloktoq (arctic hysteria), has been observed primarily among the female Eskimo population. The victim first becomes mildly irritable and withdrawn over the course of a few hours or days. In the next stage the victim will suddenly become excited, tear off his/her clothes, eat feces, as well as commit other unusual acts. The victim will finally dash from the shelter and jump into the snow or ice. This stage can last from a few minutes to a half hour. The victim will finally lapse into convulsion and then a coma which lasts for approximately 12 hours. After the attack, the victim's behavior will return to normal and he/she will have no memory of the event. Trimble, et. al. (1984)

cite one psychodynamic explanation for the disorder as symptomatic of hysteria arising from unmet needs for affection (Brill, 1913; Gussow, 1960). Another psychodynamic explanation cited by Trimble, et. al. (1984) is that the disorder is brought on by loss of desired object in an individual who has not completed the process of individuation (Freeman, Foulks, & Freeman, 1978). Other explanations for the disorder, according to Trimble, et. al. (1984), focus on environmental factors such as calcium deficiency, prolonged darkness, and the severe climate (Jenness, 1959; Novakovsky, 1924; Wallace, 1961; Weyer, 1932). What is most notable about these explanations is the focus on either the individual or the environment, instead of an integration of the two.

In order to better contrast the European based Anglo-American view of mental illness with the traditional Native American interpretation, Trimble, et. al. (1984) describe several fairly common traditional explanations for mental illness found among many Native American communities . One such explanation is "soul loss" which is a common explanation for many forms of illness and odd behavior among many tribes. According to Trimble, et. al. (1984), this concept is used to explain behaviors such as sudden repeated fainting, withdrawal, self-deprivation, and preoccupation with death and dead relatives. The etiology that is described by this concept often consists of the soul wandering in dreams and remaining in the land of the dead or the soul being taken away by dead relatives.

Another explanation, according to Trimble, et. al. (1984), which is common to many tribes, is "spirit intrusion". Spirit intrusion refers

to the presence of evil spirits, ghosts, or demons within an individual leading to symptoms similar to agitated depression. A related explanation is "ghost sickness" which explains symptoms of anxiety and generalized fear as resulting from close physical proximity to the dead.

Trimble, et. al. (1984) report another common explanation called "taboo breaking". This is used to explain illness which are thought to be the result of breaking a strong social taboo, usually relating to sexual behavior, such as incest. Other possible taboos that could lead to illness include behaviors that could seriously disrupt the harmony within the tribe, such as murder, deceit, and constant neglect of social obligations. Among several Native American communities, these illnesses are thought to be the direct result of the individual bringing bad luck upon himself/herself by breaking the taboo and risking the wellbeing of the community. In contrast, an Anglo-American explanation, which focuses on the inner states of the individual, postulates that these illnesses are the result of personal guilt, fear and superego anxiety (LaBarre, 1964).

Trimble, et. al. (1984) conclude their review of the native conceptions of illness by pointing out that many of the interpretations of these illnesses in the psychological and psychiatric literature are based on an external European world view with little understanding of the cultural context of these illnesses. Trimble, et. al. (1984) state that one major error made by researchers in studying Native American conceptualization of illness is relying on too few informants for their interpretations. This error is made

worse when information is taken from a few people and generalized to other communities and tribes without considering possible tribal differences. Another common error, according to Trimble, et. al. (1984), is that many researchers do not consider the functional aspect of a category within the culture. For example, they describe the Lakota "wacinko" behavior. Traditionally it was a culturally sanctioned means to mentally withdraw in order to find some privacy while living in crowded conditions. It currently means "to pout" among the Lakota and continues to serve the purpose of allowing the individual to withdraw from stressful situations. When a person "wacinkos" or withdraws, his privacy is respected instead of having his well-being probed. The final error, as described by Trimble, et. al. (1984), is that the writers in the literature largely formulated interpretations based on the European world view of illness rather than the world view of the community from which the illness had arisen.

Based on their observations, Trimble, et. al. (1984) argue that more research needs to be done that examines the concepts of mental health, well being and poor functioning from the Native American perspective in order to better understand how the different communities formulate these concepts. Even more important, Trimble, et. al. (1984) state, is to go beyond the almost exclusive focus on pathology among Native Americans. Trimble, et. al. (1984) point out that research needs to identify and examine the situations, developmental tasks and skills that are required of the Native American in order to function well in his/her culture. A good

beginning for such research, according to Trimble, et. al. (1984), is to examine the values and beliefs and to see how they are tied into a consistent lifestyle pattern.

Shore and Manson (1981) also examined the conflict between the European based mental health tradition and the traditional Native American cultures by exploring the conceptualization of depression in both traditions. Shore and Manson (1981) assert that depression, as an European concept, has lacked clarity within its own culture in that it includes a wide range of mood variations, physiological responses, and behaviors. In applying it to another culture with different values and beliefs, the diagnostic picture might become even less clear. For example Shore and Manson (1981) report that a study by Chance (1962) attempted to use the Cornell Medical Index with Eskimo natives. He found that only those items concerning physical symptoms had any meaning to the natives. In other words, their conceptualization of well-being and illness did not include current Western mental health concepts of intrapsychic dynamics.

Shore and Manson (1981) also describe difficulties with using standardized testing, such as the MMPI, to diagnosis more traditional Native American individuals. They describe a study by Pollack and Shore (1980) involving the use of the MMPI with Native Americans of the Pacific Northwest. Pollack and Shore (1980) found that cultural factors accounted for more variance than individual pathology and personality characteristics. In particular, they found that profiles for patients with schizophrenia were indistinguishable from patients

with nonpsychotic depression. Shore and Manson's (1981) interpretation of these results consist of possible cultural differences in the comprehension and interpretation of the word meanings on the MMPI.

In partial support of this hypothesis, Shore and Manson (1981) describe a study by Leff (1977) who translated a structured interview, which contained questions similar to the MMPI, into five Indo-European languages and two nonIndo-European languages. He found that people who spoke an Indo-European language were able to differentiate between anger, depression, and anxiety whereas the individuals who spoke nonIndo-European languages were unable to differentiate between the mood states since they had no cultural equivalent. From these results it appears that there are cultural differences in the conceptualization of affect. Since the MMPI does contain many items dealing with different forms of affect, it is quite possible that nonEuropean language based cultures, such as traditional Native American cultures, might have difficulty translating the questions into their culture. As Shore and Manson (1981) point out, in order to arrive at a more accurate assessment of the emotional state of the Native American client, it is important to better understand how various forms of emotional disturbance are conceptualized in different Native American communities.

As a step in achieving this better understanding, Shore and Manson (1981) examined different traditional Native American depressive syndromes. The first one they describe is the Windigo psychosis which is found among the Cree, the Eskimo, and Ojibwa of

Northern Canada. As described by Trimble, et. al. (1984), this syndrome is characterized by symptoms of melancholia, delusions,and a compulsive desire to eat human flesh. Shore and Manson (1981) interpret this syndrome as resulting from a dysfunctional struggle for survival. Another form of depression described by Shore and Manson (1981) is the Hiwa-Itck syndrome which translates as "heartbreak". This is a depressive syndrome found among elderly Mohave males who have been deserted by their young wives. The symptomology alternates between agitation and despondancy. The Native Mohave state that the depression is caused by too much worrying. Most notable from both of these descriptions is the focus on external behaviors and the social context of the disorder. Furthermore, it can be noted that the traditional Native American explanations do not extensively analyze the internal mental and emotional states of the individual.

Shore and Manson (1981) also describe the Wacinko syndrome found among the Lakota. Similar to Trimble, et. al. (1984), they describe the syndrome as involving varying degrees of anger, withdrawal, feelings of despondency, a slowing of bodily movements, loss of speech, immobility, and occasionally suicidal behavior. Lewis (1975) interprets the syndrome as indicative of mild to severe reactive depression. In contrast to this Anglo-American conceptualization, Shore and Manson (1981) point out that among the Lakota, this syndrome is not viewed as pathological depression. Rather it is more a feeling state of anger or moodiness. As Trimble, et. al (1984) point out, it appears to be a culturally sanctioned

manner for dealing with stressful situations. Once again, it can be noted that this particular Native American explanation focuses on the social context of the syndrome instead of the internal emotional states.

In general, it is apparent that the various accounts of depressions from the different Native American communities tend to focus more on external behaviors and the social context instead of being focused on the individual's inner emotions and mental state of well-being. This is consistent with Trimble, et al's (1984) observation that self-revelation and insight is not encouraged or common among many Native Americans. Therefore, trying to assess depression, or other psychiatric syndromes, by focusing on affect and inner states, such as through the MMPI, may be culturally inappropriate. Rather, Shore and Manson (1981) argue, it appears that among many Native American communities, such concepts as depression tend to be based more on external behaviors and the context of the social interrelationships and therefore, should be assessed as such among the Native American communities.

As a more specific example of how a Native American community might conceptualize and explain mental disorders, Spaulding and Balch (1985) conducted a survey among the Yaqui Indians in Arizona. In their interviews with the Yaqui, the researchers used vignettes of behavioral descriptions. These descriptions were based on the original vignettes used by Starr (1955) who first developed behavioral descriptions of mental disorders in order to research people's perceptions of mental

disorders. After the behavioral description was read, each subject was asked if something was wrong with the person in the vignette, if the person was suffering from a mental problem, if help would be sought if this problem occurred in the subject's family, what the source of help would be, what would cause the behaviors, and if the subject knew anyone who demonstrated behaviors similar to the ones in the vignette. The subjects consisted of the urban based Yaqui Indians, with the majority of the respondents being female and the average education level at 9th grade.

In the first vignette, which described a man with paranoid delusions, 95% of the subjects stated that something was wrong with the man, that he was suffering from a mental problem, and that it was extremely serious (Spaulding & Balch, 1985). The researchers reported that the majority of the reasons given for the cause of behavior fit into the category of "other individual psychological problems" (Spaulding & Balch, 1985, p. 21). The researchers also found that the majority of the subjects would seek help for the individual, with the most frequently mentioned resource being a clinic or a psychiatrist. Finally, they found that 37% of the subjects reported knowing someone with similar problems.

The second vignette described a woman with simple schizophrenia in that she tended to be reclusive, didn't talk much, and was painfully shy around visitors. Spaulding and Balch (1985) report that 65% of the subjects stated that something was wrong with the person's behavior but only 40% stated that she was suffering from a mental problem. Furthermore, the researchers

found that 34% of the subjects felt that the problem was moderately serious and 26% of the subjects reported that it was mildly serious. The researchers report that 39.5% of the explanations given for the problem fit the category of "other psychological problems". The researchers also found that 15% of the subjects state that they did not know where they would seek help for the person and 19% stated that no help would be sought. Among those who would seek help, the three most frequently mentioned options were counselor, clinic, or family or friend. The researchers report that 45.7% of the subjects stated that they knew someone with similar behaviors.

In the third vignette, which described a man with alcoholism, 90% of the subjects stated that something was wrong with the man, although only 46.9% believed that he had a mental problem (Spaulding & Balch, 1985). Of those who thought he had a mental problem, the researchers report that 45.2% of those subjects stated that the problem was very serious and 26.2% stated that the problem was extremely serious. According to the researchers, 51.9% of the subjects stated that the behaviors stemmed from alcohol or drugs. The researchers found that the vast majority of the subjects would seek help for the individual, with 34.6% of the subjects reporting that AA or some other alcoholic treatment would be sought and 20% of the subjects unsure of where they would seek help. 75.3% of the subjects stated that they knew someone with this problem.

The fourth vignette described a woman with compulsive-phobic behavior. Spaulding & Balch (1985) report that 49.4% thought the behavior was not a problem and 45.7% thought it was a problem.

Furthermore, according to the researchers, half of the subjects who thought it was a problem stated that it was a mental problem while the other half thought it was not. Of those who thought it was a mental problem, 40% stated it was moderately serious and 30% stated it was very serious. The researchers also report that 37% of the subjects thought that the behavior was the result of other individual psychological problems, although 50% of the subjects did not respond to this questions at all. The researchers found that 17.3% of the subjects indicated that they would not seek help at all, 22.2% stated that they would seek help and another 50% of the subjects did not respond either way. Finally, the researchers found that 48 % of the subjects replied that they knew someone who demonstrated similar behavior.

In the fifth vignette, which describes a boy with behavioral problems, 77% of the subjects stated that something was wrong with the boy (Spaulding & Balch, 1985). Furthermore, the researchers found that 39.5% believed he had a mental problem and 35.8% believed that he did not. Of those who believed that he did have a mental problem, 41.7% believed it was very serious and 27.8% believed it was moderately serious. The researchers report that 40.7% of the subjects explained the boy's behavior as being the result of treatment by others, as well as poor parenting. Another 13.6% stated that the behavior was the result of family problems. The researchers also found that 24.7% of the subjects were unsure of where to go for help in such situations, while 18.5% stated that no help at all would be sought. Finally, the researchers report that

55.6% of the subjects stated that they knew someone with this difficulty.

Spaulding & Balch (1985) proposed that cultural roles and values may have had a strong effect on the subjects' responses. For example, in the vignette about the woman with simple schizophrenia, even though a large majority of the people believed something was wrong with her, only 40% stated that it was a mental problem. The authors assert that this finding is different from similar studies conducted among Caucasian American communities where respondents were much more likely to label the behavior as indicative of a mental problem. Furthermore, the subjects in the present study who perceived a mental problem, believed it to be only mild or moderately serious. Finally, 15% of the subjects stated that they were unsure of where to find appropriate help for this difficulty and 19% stated that no help at all would be sought. In other words, even though the majority of the subjects believed this to be a problem, they did not view it as a serious problem that needed immediate solution. Spaulding & Balch again assert that this differs from findings of similar research conducted among Caucasian-American communities. The explanation given by Spaulding & Balch is that within the Yaqui culture, the woman's role is generally considered to be the primary caretaker of the home. Therefore it appears that the subjects view this behavior as being within cultural limits, even though it may be considered a little odd. This supports the proposition that, even though different cultures may view the

same behavior as troublesome, they may still differ in the degree to which it is considered a problem.

Another phenomenon that suggests fundamental differences between the European and traditional Native American conceptualization of health and illness is the fate of attempts at collaboration between American health care professionals and Native American healers. Manson (in press) describes a situation in the northeastern part of Canada where a rural community hospital attempted to hire a native healer as a staff member in order to facilitate care of Native American patients between the two cultures. Some of the Native American community members opposed the arraignment since they believed that it would disrupt the sacred powers of the native healer. According to their beliefs the healer, the people, the natural surroundings, and the spiritual forces are all bound together in an interrelationship that provided continuity between past and future. They believed that the hospital setting would disturb that relationship which would render the powers of the healer ineffective. Even though the hospital administrators had good intentions, some of the people still viewed the attempted action as harmful based on their world view.

Interaction of Anglo-American and Native American Mental Health Values Through Collaboration Healing Attempts

In a another more indepth look at issues involved with collaboration between health care professionals and native healers, Manson (in press) interviewed 47 native healers from the northwestern, southwestern, and midwestern areas of the United

States concerning 60 cases of collaboration with Anglo-American health care professionals. Since his observations are based on the accounts of the native healers, the study provides a good inside view of the traditional values of several Native American communities. Based on his interviews, Manson proposes that collaboration involves six main elements: definition, explanation, credibility, reimbursement, patient expectations, and professional integrity. According to Manson, these issues involve differences in the ways in which traditional healers and Anglo-American physicians conceive of their respective crafts and of the particular values system behind the craft. These issues also demonstrate the different formal and informal mechanisms by which services are made available to the community, as well as the different ways that healers in both traditions relate to the patient and the community.

The definitional element according to Manson involves the difficulties associated with attempting to create meaningful interpretations of illness between the two cultures. As Manson points out, many native categories of illness do not often translate well to Anglo-American terms since some etiological factors (i.e. soul loss, spirit intrusion, breakdown in connection between individual and community) do not have a parallel in the European world view. Furthermore, Manson asserts, the psychiatric syndromes, which are strongly focused on the individual's inner mental and emotional states, do not translate well to many traditional Native American conceptualizations which focuses more on the individual in relation to community, nature, etc. As Manson argues, this struggle is evident

in such terms as "culture bound syndrome" and "white man's disease". However, Manson found from his interviews with the native healers that this is not particularly a problem unless there is an attempt to integrate the native healer within the health care institution.

The second element involves the attempts of the healer to explain how a procedure works. According to Manson, the explanation of a procedure is based on shared assumptions and language. Since the health care professional and the native healer do not have these shared assumptions and language, they experience greater difficulties in explaining to each other their methods. A further difficulty, according to Manson, is that the manner in which illness and cure are described are quite different between the two cultures. Manson asserts that the native healer tends to talk in metaphors and allegories when describing the problem and the solution, whereas the health care professional is concrete and descriptive in his/her speech. However, Manson found from his interview that even though this was cited as one of the biggest sources of difficulties, it was not predictive of either perceived success or failure of the collaboration.

The third element, according to Manson, involves establishing credibility with the healer in the other culture. Within each culture there exists a certain protocol, or prescribed set of behaviors, that are followed as part of the collaboration process. Since these collaborations are between members of two different cultures, the protocol of one culture maybe unknown or misunderstood by the

other culture. For example, Manson describes one situation in which a psychiatrist directly approached a local healer, introduced himself, and requested his help. Receiving no immediate response, the psychiatrist repeatedly approached the healer. Since this was viewed as inappropriate by the native healer, no help was given to the psychiatrist. Manson asserts that in the Native American community credibility is established and maintained, not through credentials, but mainly through personal experience with the healer and his/her skills. Manson found from his interviews that credibility is an important part of the collaboration relationship since 51% of the ventures that were labeled as unsuccessful by the native healers were marked by credibility difficulties whereas only 17% of the successful ones involved problems with this issue.

The fourth element concerns reimbursement of the native healer. According to Manson, the Indian Health Service (IHS), which is a major provider of health care to Native Americans, is often reluctant to reimburse the services of a healer without some way of confirming their status as healer within the community. This is made even more difficult by the fact that most communities lack a precise definition of or set of criteria for "community recognition". This recognition is gained through shared experiences with the community rather than meeting some set of criteria. Manson also found from his interview that direct compensation of the healer may not always be culturally appropriate. For example, he relates one situation where a native healer was embarrassed and angered by an unrequested consultation fee from the institution, since traditionally

his services are compensated by the patient as part of the interrelationship between them. He does point out, however, that even in those situations in which reimbursement was considered inappropriate, the native healer still appreciated the attempt as a sign of respect. He found that this issue was cited as a problem by the native healers in only 10% of the cases and that the majority of those collaborations were considered successful by the native healers.

The fifth element described by Manson is patient expectations. He argues that it is the patients who ultimately choose whether or not they would like to have collaboration between the two healers. He further states that many times the patient already knows what kind of services they are seeking from each person and, therefore, do not need or want the two healers talking with each other. For example, Manson describes a situation in which an elderly Native American woman went to a psychiatrist seeking relief for headaches and muscle pain. The psychiatrist learned from his interview with her that she was also experiencing dizziness, fainting spells, and brief periods of amnesia for which no organic basis could be found. The patient also told the psychiatrist that she had been seeing a medicine man frequently. When the psychiatrist offered to talk to the medicine man, she refused. The psychiatrist leaned later that the woman believed that her symptoms were the result of a curse and was going to the medicine man to alleviate the cause. She had sought the services of the medical professionals only for alleviation of the symptoms until the final cure was brought about by the medicine

man. Manson found that this issue was cited as a major problem by the native healers in 1/4 of the cases he investigated and that it was cited as a difficulty in 80% of the cases considered to be unsuccessful by the native healers. This indicates the necessity of understanding the patient's values and the patient's evaluation of different sources of help.

The sixth element described by Manson is professional integrity which involves the values and beliefs that are used by the health care professional and the native healer to form their identity as healer and caretaker. As Manson points out, the values and beliefs that are used by the healer as the basis of this identity strongly influences their attitude towards other healers. For example, Manson found that some health care professionals experienced difficulty collaborating with the native healer since the methods and beliefs of the healer conflicted with the professional's values and beliefs. From the other side, Manson found that many native healers are sometimes reluctant to work with a doctor since the structure of the collaboration makes them feel like they are working for the doctor. Furthermore, according to Manson, some native healers are afraid of losing power and reputation if they work with the health care professionals since the collaboration may violate their values and beliefs. The initial example provided by Manson is a good demonstration of this issue. Manson found that this element was cited as a problem by the native healers in half of the cases he investigated. He also found that 3/4 of those cases were labeled as unsuccessful by the native healer.

In reviewing this study, it is notable that the areas that involved the greatest conflict, such as credibility, patient expectations, professional integrity, and to some degree definitional issues, center around the values of health, illness, and acceptable methods of help for both cultures. Much of the conflict in these areas appear to arise from a lack of understanding, openness, and communication between the two cultures concerning these fundamental values. That is why Manson proposes that the most successful collaborations will most likely come from community based health care professionals who have taken the time and effort to become familiar with the values and beliefs within that particular community.

Native American Values in Healing

Michael Martin is one such professional who has worked closely with native healers and the native traditions. Martin (1981) described his observations of traditional Native American beliefs and practices concerning health and illness. He first asserts that the traditional Native American individual in many communities feels connected with the people and the environment. This sense of connectedness along with the spiritual orientation of the culture influences traditional practices in two ways. One way is through the healer's concern with the relationship of the patient to his/her surroundings. The other way is through the culture's emphasis on ritual and ceremony which reestablishes relationships with others. As Martin asserts, this is based on the belief that illness is the result of the lack of harmony with the individual's surroundings.

Since, according to Martin, illness is viewed as being the result of the disruption of this harmony, the patient's sickness places a responsibility on the patient and the family to participate in a healing ritual in order to reestablish that harmony. Therefore, the healer does not focus exclusively on the individual and his/her disease. Instead, he focuses on the people's reaction to the illness and involves the patient, family, and other community members in the ritual. Since an important aspect of the healing process involves reestablishing the individual's connection with the community, the healer surrounds himself with helpers who support the ceremony and the patient. The helpers' job also includes welcoming the patient, listening and answering questions and making him/her feel comfortable. Therefore, it appears from Martin's observations that traditional curative practices within many Native American communities focus on reconnecting the individual with the community through ceremony in order to reestablish the family and tribal harmony.

It is apparent from the literature that the traditional approach to illness and healing in many Native American communities is different from the European health care model and that awareness and utilization of this approach in the current health care system may be helpful for working with Native American communities. Similar to Manson's (in press) and Martin's (1981) observations, Lafromboise (1988) argues for the importance of understanding and incorporating traditional Native American values and practices into mental health services for Native Americans. For example, she

describes a number of successful tribally based mental health programs which have included the use of the traditional healer's services as a central aspect of the program rather than as an adjunct to typical Anglo-American methods. According to Lafromboise, an important aspect of these programs is that they reinforce traditional ways, which helps to strengthen the identity of both individual and community. She also asserts that the most effective methods are those that utilize traditional community and kinship support networks, since many Native American communities still rely on these informal networks to care for each other. She cites Attneave's (1969) network therapy as an example of an approach based on the Native American relational values. Attneave worked with urban based Native Americans who had lost much of the traditional network as a result of the move to the city. She worked with these groups to rebuild the network with the friends and family that were present in order to give each other the support and help they needed to work through different stressors.

Lafromboise (1988) proposes that many Native American communities conceive of life as consisting of many interconnections among people, the environment, spirits, etc. To attempt to focus on and work with only one aspect of those connections is inconceivable to many Native American communities . Unfortunately, according to Lafromboise, that is exactly what psychology often attempts to do by focusing on only the individual or even just one aspect of the individual. Many of the psychological concepts do not embody the holistic view of life that is common in many Native American

communities. Lafromboise asserts that with the emphasis on maintaining the interconnected network of the community, "mental health" or "well-being" is demonstrated through prosocial qualities and self-control instead of certain internal emotional and mental states. Some Native American communities, Lafromboise argues, view behavior disturbance, or mental illness, as being the outcome of not fulfilling one's duties to the community and not keeping with the community values. Therefore the emphasis is on the communal network instead of exclusively on the individual's symptoms. With this value on maintaining the communal network, Lafromboise observes that the family and friends of the individual with the symptoms will gather around the person and draw him/her out of isolation and back into the community. For this reason, treatment usually involves many people in order to reconnect the individual. The goal of treatment, according to Lafromboise, is to strengthen community ties in order to find new solutions through the interrelationships of the people.

According to Lafromboise (1988), part of the difficulty with Western psychology is that the European tradition is based on a dualistic view of the world that separates the individual and the community, which, she argues, weakens community ties and diminishes a sense of rootedness in time and place. Lafromboise asserts that this world view, along with the individualistic focus is reflected in the therapeutic training which is often exclusively individual oriented and does not include community consultation, social change intervention, or community networking and building.

Lafromboise also states that this value system is also reflected in mental health prevention efforts which are often prepackaged programs aimed at specific individuals instead of targeting the needs of the community with a flexible approach. Lafromboise also observes that the university trained professional often has incorporated an attitude that he/she is the only valid source of help with no awareness of the natural resources offered by the community. This attitude also influences the professional's view of alternative healing approaches within the community as being unenlightened and inferior since it is "nonscientific". In essence, Lafromboise argues that psychology needs to become more community oriented in its values and attitudes when working with Native American communities.

Based on her observations and opinions, Lafromboise (1988) made a number of recommendation concerning the training of psychologists as well as the development of mental health programs. She proposes that training programs in psychology should include education on the impact of the cultural environment and context on Native American behavior. She also proposes that training should include community based internships that will provide opportunities to learn how Native American communities are organized, supported, and developed in order to build networking skills and to learn how to utilize families and friends as support systems. According to Lafromboise, mental health workers should become acquainted with indigenous methods of healing before attempting to develop mental health interventions. She further asserts that services should build

on client strengths as well as help them to strengthen their ties to the community. She also states that evaluation of the client should include assessment of the client's support system.

Guilmet,.et. al. (1988) describe their observations of the mental health needs of the Puyallup in Tacoma, Washington. These authors also emphasize the importance of the community network in the life of the individual as well as in understanding the values of the individual's community. Guilmet,.et. al. state that a main element in the traditional Puyallup culture is a spiritual, holistic approach to healing. According to Guilmet,.et. al. , the holistic approach involves a socially organized approach which tries to treat the whole person. Similar to Martin (1981), Guilmet, et. al. point out that the traditional Puyallup healer is primarily concerned with the relationship between the patient and his/her social, environmental, and spiritual surroundings. This results from the traditional Puyallup belief, similar to that of other Native American cultures, that disease and illness are the result of the breakdown in the harmony between the individual and his/her surroundings. Therefore the traditional Puyallup healer emphasizes ritual in the healing process as a way of incorporating social relationships in a curative ceremony.

Unfortunately, according to Guilmet, et. al. (1988), many of the Anglo-American health care professionals who have attempted to serve the Puyallup people through the years have historically assumed that the people were without established health customs of their own. As a result they imposed their own European based health care system upon the people without regard to the people's

traditional health care values. Guilmet, et. al. assert that this has led to the present day situation in which the traditional holistic approach of the Puyallup people has been replaced by a series of fragmented interventions provided by health care professionals who are working from a European, biomedical tradition. A further tragedy, according to Guilmet,.et. al., is that urban life has disrupted the extended family networks of many Puyallup people who already feel alienated from the majority culture. They propose that the best way to remedy the situation is to formulate health care programs which are more holistic, spiritually based and which incorporate traditional healing practices. They cite as an example an alcohol and drug treatment program for the Puyallup which integrates Western and native treatments through a Medicine Wheel approach that considers the social, psychological, physical, and spiritual aspects of the individual's illness. Guilmet,.et. al. conclude that the mental health of the Puyallup people will only improve when their culture is reintegrated.

A study by Minton and Soule (1990) conducted among the Eskimo people, further demonstrates the importance of community networks on the well being of the individual. The goal of the investigators was to interview inhabitants of two Eskimo villages regarding the level of their mental health and the factors that influence their mental health. When they approached the leaders of the two villages, they were informed that the concept of "mental health" had little meaning to the people. As a compromise, they received input from community meetings regarding more relevant and appropriate questions. The leaders of the two villages also chose

eight bilingual individuals to act as interviewers for the study. The researchers then refined the questions, trained the interviewers, and gained the approval of the leaders for the study. The questions were framed in terms of "what makes you sad, what makes you happy, where do you go when you are sad?" The age groups, which were selected by the village people in a community meeting, consisted of ages 7-18, 19-29, 30-54, and 55+. Between the two villages, 216 people were interviewed. Thirty percent of the people chose to be interviewed in their native tongue, while the rest chose English.

Minton and Soule (1990) found that for all subjects, the primary source of happiness was other people and outdoor activities. The primary sources of sadness, overall, was death, alcohol, other people, and negative events. The preferred sources of help for dealing with sadness for subjects overall were found to be friends, religion, parents, and relatives. The researchers found that people in the age group of 7-18 cited school and victimization as a source of sadness, significantly more than the other age groups. The researchers also found that references to good daily living, children, and religion as a source of happiness increased with age. They also found that sports, friends, walking around, family, and going to school decreased with age as a source of happiness. Overall, female subjects rated children, good health, religion, and relatives as a source of happiness significantly more than the male subjects. Male subjects, however, rated doing things with others as a source of happiness significantly more than females.

Based on their findings, Minton and Soule (1990) point out that a number of gender-related and age-related differences exist within the community which suggests the possible necessity for being sensitive to individual differences when working within a native community. In general, though, Minton and Soule (1990) found that the sources of happiness for the majority of the community people were oriented towards outdoors and other people which demonstrates the importance, for the native person, of living in a harmonious community. They concluded from these results that mental health interventions that focus solely on the individual may be ineffective since they would ignore the impact of the social network upon the individual's life.

Minton and Soule (1990) also found that for all subjects great emphasis was placed on other people and religion as a source of help when sad. This, according to the researchers, suggests the importance of helping the community to create interventions based on communal strengths rather than relying solely on outside agencies. Based upon the results, Minton and Soule propose that mental health workers need to allow community members time to get to know them as individuals, work at a slower pace, provide services in informal settings. and view the community rather than the individual as the target for intervention. As an example,Minton and Soule describe the Four Worlds Project in Canada which emphasizes local initiatives, integrating native traditions with self-help programs, and using indigenous service providers with consultation from other sources as necessary (Bopp, 1987).

Examples of the use of Native American Values in Implementing Services

As a demonstration of a mental health initiative that is based on Native American communal values, Red Horse (1982), has formulated a treatment strategy that is based on building and maintaining extended family interrelationships. He proposes that traditional Native American families are typically organized as closed communities that are spiritually motivated and oriented toward maintaining extended family bonds. Therefore he has developed a service called "cultural network model" that would bring families together in a collective for therapeutic support along with health professionals to serve as cultural and social role models. According to Red Horse, it would include all ages and would reaffirm the cultural and structural integrity of the extended family system while incorporating existing therapies. He further states that such a model would necessitate the daily involvement of staff within the family.

Red Horse (1982) describes the program as being organized around four principles. The first principle deals with spirituality issues which would involve incorporating a spiritual leader as part of a team in order to help with spiritual guidance and balance. The second principle deals with the immersion of the clinician into the family system by assuming a role, such as aunt, uncle, or cousin. Red Horse states that this is necessary since the family tends to be a closed system. Furthermore, by assuming a role as family member, the clinician can model healthy interdependent behavior. The third principle is "picturing" which involves helping the family to evaluate

behaviors and goals in terms of how they affect the group as a whole and assisting them in establishing some common goals. The fourth principle consists of joining or hooking fractured families back together. This requires immersion so that the professional is aware of the possible connections to be joined. The essential benefit of this approach,according to Red Horse, is that it focuses on reconstituting the extended family instead of modifying the behavior of one individual, thereby creating less stress and less value conflict.

As an example of a mental health program that attempts to work with existing community resources and networks, Guilmet and Whited (1987) describe the Kwawachee Mental Health Counseling Center of the Puyallup Tribe, which is a tribally based mental health program. Since the program is operated by the tribe, the mental health workers have taken the effort and time to become acquainted with the area's "culture map" which refers to the various tribal and familial connections and resources specific to the Native American people in the Tacoma area. The workers use this network to distribute information, gather ideas and support for clinical services and as a source of referrals. The workers also participate in community and tribal events as well as attend such events as funerals to provide personal support. The workers also utilize this network to gain access to existing traditional healing ceremonies for clients in need.

Purpose and Description of Study

Overall it appears from the literature review that one of the fundamental traditional Native American values is the emphasis on

the wellbeing of the tribe through maintaining harmony among tribal and extended family members as well with physical and spiritual surroundings. This in turn is accomplished through cooperation, sharing, and spiritual ceremonies. Another traditional value is respecting the individual's privacy and decisions. These traditional values are associated with a holistic conceptualization of illness as the disruption in the harmony of the relationships between the individual and his/her social, physical, and spiritual surroundings. Interpretation of symptoms, therefore, appears to be accomplished in the context of social and spiritual influences instead of an individual's inner emotional and mental states. Several authors have proposed that these traditional values of health and illness should be incorporated into mental health programs for Native Americans in order to make these programs more culturally appropriate (Guilmet and Whited, 1987; Heinrich, Corbine, & Thomas, 1990; Lafromboise, 1988; Manson, in press; Minton and Soule, 1990; Sue and Sue, 1990;Trimble, Manson, Dinges, & Medicine, 1984)

Since much of the literature is based on personal and subjective observation, more empirical research concerning Native American mental health values needs to be conducted in order to develop more culturally appropriate interventions. As Trimble, et. al. (1984) proposed, one way to better understand Native American mental health values is to examine the ways in which these values are tied into a consistent lifestyle pattern. Therefore important questions for such research should include: how might particular behaviors and attitudes be evaluated in terms of mental health?

What areas of life are deemed to be most important for good mental health? This study explores these questions with the Mental Health Values Questionnaire, MHVQ, (Appendix B) developed by Tyler, Clark, Olson, Klapp, and Cheloha (1983). This instrument asks the individual to evaluate specific behaviors and attitudes in terms of mental health. The evaluations of these behaviors and attitudes are then grouped into eight dimensions, or scales, which can be used to conceptualize different areas of healthy emotional adjustment. The eight dimensions, or scales, consist of Achievement, Affective Control, Negative Traits, Good Interpersonal Relations, Self-Acceptance, Untrustworthiness, Religious Commitment, and Receptivity to Unconventional Experiences.

Another aspect of examining how Native American mental health values are connected to a daily lifestyle pattern is to consider such questions as: how are different life problems perceived in terms of severity? What are the preferred options for help with life problems? As noted in the review of the literature, there is evidence which suggests that an individual's basic value orientation and cultural background will strongly influence how he/she will perceive a particular problem situation, especially in terms of acceptable sources of help and the degree of problem severity. (Minton & Soule, 1990; Spaulding & Balch, 1985).

This study addresses these questions by using the Sources of Referral Questionnaire (Tyler & Suan, 1989). Like the instrument devised by Spaulding and Balch (1985), this questionnaire consists of vignettes that describe such situations as relationship problems, child

behavior problems, nonsituational depression, paranoid auditory hallucinations, and violent behavior. The Sources of Referral Questionnaire is somewhat more inclusive than the Spaulding and Balch instrument, since it includes life problem situations, as well as psychiatric disorders. The questionnaire asks the subject to rank order six resource options from first choice to last choice for each situation. For the purposes of this study three vignettes were added (grief reaction, somatic problems, and visions) and the violent behavior vignette was changed to include alcohol as the contributing factor. These changes in the vignettes were made in order to better approximate situations on some reservations. Furthermore, an extra resource option was added and the subjects, instead of rank ordering, were asked, for each option, to rate how likely they would recommend a particular option for a particular problem. Extra questions, derived from the Spaulding and Balch (1985) research, were also added to assess the individual's perception of the severity of the problem (Appendix C).

Since differences between tribes have been documented in the literature (Trimble, Manson, Dinges, & Medicine, 1984; Shore & Manson, 1981), an important component of examining Native American mental health values is to investigate these questions: Are there tribal differences? What factors may be associated with these differences? In order to address these questions, three tribes were selected that differed in terms of traditional lifestyle and/or amount of interaction with the other tribe shortly before and during the advent of Caucasians. Participants were recruited from three Native

American reservation-based colleges; two Northern Plains and one High Plateau.

The two Northern Plains tribes, Tribe 1 and Tribe 2 were traditionally nomadic tribes which roamed widely across the plains hunting, mainly buffalo, and gathering berries, roots, and other vegetation (Grinnel, 1972; Hyde, 1959). The tribes were generally divided into clans which remained separate for most of the year. Tribal structure was maintained through the use of societies and strict tribal codes. A few times a year the clans would come together for a full tribal meeting to renew social ties, to strengthen ties among clans and to discuss important issues for the tribe. Even though the two tribes were traditionally similar, historical records do not indicate much interaction between the two tribes during the 19th Century.

Members of the High Plateau tribe, Tribe 3 were a semi-nomadic people who spent about six months of the year in one locality fishing, and hunting deer, antelope and sometimes buffalo and spent approximately six months in another locality gathering roots and berries and settling in for the winter (Fahey, 1974). Men would go in small groups to the Plains to hunt buffalo, but generally the tribe as a whole would not go. Historical records indicate that Tribe 3 had a fair degree of interaction with Tribe 1 during the 19th Century, although much of it was hostile. Historical records do not indicate that Tribe 3 had much interaction with Tribe 2 during the 19th Century. Therefore the breakdown of the tribal comparisons are as follows. Tribe 1 was tradtionally similar to Tribe 2 but did not

have much interaction with Tribe 2. Tribe 1 was traditionally dissimilar to Tribe 3, but had a fair degree of interaction with Tribe 3. Tribe 2 was traditionally dissimilar to Tribe 3 and did not have much interaction with Tribe 3.

Since Native Americans vary in the degree to which they follow traditional practices and values (Sue & Sue, 1990; Hienrich & Corbine, 1990), it is possible that this might also be a potential source of variance in mental health values. For this reason, a background questionnaire (Appendix A) was used to ascertain the degree that each Native American participant identified with and was involved in traditional Native American beliefs and practices. The development of the questionnaire was influenced by Sue and Sue's (1990) observations that some of the indications of traditionality include involvement in tribal and traditional practices, and social involvement with other Native Americans. Since Minton and Soule (1990) found gender differences in the perception of mental health issues, gender was also examined as a potential source of variance in Native American mental health values.

Since the literature review also examined the theoretical differences between traditional Native American values and Caucasian values in order to highlight the unique aspects of Native American views, an empirical examination may help to clarify the differences and similarities in the mental health values of the two races, which, in turn, could aid in the adaptation of mental health strategies to Native American communities. For this reason, the study compared the Native American responses on the MHVQ and

the Sources of Referral Questionnaire with the responses of a Caucasian sample drawn from the University of North Dakota. A similar comparative study was carried out by Tyler and Suan (1990) who administered the MHVQ to a sample of Native American college students and a sample of Caucasian college students who were attending the same Northern Plains University. They found significant differences between the two groups on the Religious Commitment and Receptivity to Unconventional Experiences scales. Essentially, the Native American subjects were more likely to rate those behaviors as indicative of good mental health than were the Caucasian subjects.

Since the Native American population traditionally has a strong focus on maintaining harmony within the community, it is predicted that Native American subjects will more strongly rate Good Interpersonal Relations as indicative of good mental health than will the Caucasian sample. Even though this finding was not obtained in the study by Tyler and Suan (1990), it is possible that the reservation based Native American sample in this study might be somewhat different from the university based Native American sample in the Tyler & Suan (1990) study, in terms of traditionality and being group focused. Furthermore, since Native Americans traditionally have a strong emphasis on maintaining spiritual harmony through daily spirituality, visions and communicating with spirits, it is predicted, similar to the Tyler and Suan (1990) findings, that, relative to the Caucasian sample, the Native American sample will more strongly

rate Receptivity to Unconventional Experiences and Religious Commitment as indicative of good mental health.

In order to make the comparison between the two cultures more congruent, a variable similar to Native American traditionality was sought for the Caucasian sample. A close correlate of Native American traditionality within the Caucasian population would appear to be religious and spiritual involvement. A series of Gallup polls (Religion in America, 1985) have found that for approximately 1/3 of Americans, religion is the most important dimension of their lives. For another 1/3 of Americans, religion is considered to be an important aspect of their lives, although not the most important. Even among many mental health professionals, religious and spiritual involvement appears to be an important aspect of their lives. Bergin and Jensen (1990) in a national survey of 425 therapists (marriage & family counselors, clinical psychologists, psychiatrists, and clinical social workers) found that religious and spiritual involvement strongly influences the lives of many therapists. In the survey, 77% of the therapists agreed with the item "I try to live my life according to my religious beliefs" and 46% of the therapists agreed with the item "My whole approach to life is based on my religion (Bergin & Jensen, 1990, p. 6)."

It does appear that degree of religious involvement might influence mental health values differently from Caucasians who are not involved in such activities. Jensen & Bergin (1988) found a significant relationship between religious affiliation and the person's conception of mental health (a questionnaire different from the

MHVQ was utilized for their study). They found that agnostics and atheists agreed significantly less than traditional religious participants with the idea that human relatedness and interpersonal commitment are important to good mental health. They also found that Christians agreed significantly more than agnostics and atheists that regulated sexual behavior and religious values are important to good mental health. Overall they found that nonreligious subjects agreed less than the other subjects with the importance of human relatedness/interpersonal commitment and spirituality/religiosity for good mental health. Since Caucasians constituted 94% of the subjects, it is probable that religious and spiritual involvement is an important influence on mental health values among Caucasians.

Since it does appear that Caucasian religious and spiritual involvement, like Native American traditionality, might influence mental health values, as well as choice for help with problem situations, this variable was included as a measure for the Caucasian population. A background questionnaire was used to ascertain the degree of identification and involvement in traditional Christian religious practices, since the vast majority of the population from which the Caucasian sample is being taken is Christian. The use of this variable enabled the analysis and comparison of the two cultures to be more congruent. Furthermore, since the author has observed Caucasians involved in traditional Native American practices, the background questions concerning traditional Native American beliefs and practices have was given to the Caucasian subjects. Finally, since many Native American groups have been exposed to Christianity and

since the author has observed several Native Americans presently participating in Christian traditions, the Native American sample has was given the background questions concerning Christian beliefs and practices. Another category was created to ascertain the degree of identification and involvement in other spiritual traditions for the few subjects that might not fit either category (Appendix A).

In summary, the main purpose of this study was to investigate Native American mental health values in the hope of obtaining information useful in guiding the development of culturally appropriate mental health strategies. This was accomplished in this study by examining the evaluation of behaviors and attitudes in terms of mental health, and the perception of the severity of different life problem situations along with the preferred options for help. As part of this investigation, the study also examined variations in Native American mental health values associated with tribal membership, traditionality, and gender. This study also compared the responses of the Native American sample with a Caucasian sample in order to further highlight the unique aspects of Native American mental health values.

Native American Research Issues

This final section deals with the issues that need to be considered when attempting to carry out research with Native Americans. Lafromboise and Plake (1984) summarize several important considerations in attempting research with Native Americans. They suggest that the researcher should consider such issues as sovereignty of the Native American people, possible tribal

differences, effects of varied levels of traditionalism upon subjects, and the appropriateness of research strategies to Native American world view. They also advocate gathering community input in all stages of the research product. In examining past psychological and sociological research, Lafromboise and Plake (1984) found that the majority of the research was negative and problem oriented and had studied only the dysfunctional members of the culture. Furthermore, much of the research had not related the study to the community's needs. They propose that future research among Native Americans should expand its focus to include positive aspects of the community and should be evaluated in terms of involvement of community members.

Darou, Hum, and Kurtness (1993) examined the experiences of a Native American tribe in Canada with psychology researchers in order to pinpoint the issues that facilitate or compromise the researcher's relationship with the tribe. In their review of the literature, they relate four steps as described by Trimble and Lee (1981) that are important in conducting research among Native Americans. The four steps are:

"1. Obtain formal consent and cooperation.
2. Organize a local advisory committee.
3. Prepare culturally sensitive instruments and interviews.
4. Provide feedback after the project completion" (Darou, Hum, & Kurtness, 1993, p. 326).

Darou, Hum, and Kurtness (1993) report a number of complaints from tribal members to illustrate inappropriate and appropriate ways to conduct research among Native American communities. In

one situation, a university research assistant arrived in a remote tribal village and approached the authorities separately to request permission to conduct the study. He was repeatedly turned down by each authority until one member, who was unaware that the other members had refused him, granted him permission. When the leaders met together, they realized that they had been put in a position of conflict by the researcher. At that point they immediately told the researcher to leave.

In a positive example reported by Darou, Hum, and Kurtness (1993), a psychology student studying social relations within a tribal community hospital, took the time and effort to establish authentic social relationships and conveyed respect for the tribal authorities. At the end of her study, she made a number of practical suggestions for the hospital authorities and even followed up on these suggestions. She also returned to make an oral report to the tribe and the hospital.

CHAPTER II

METHOD

Subjects

The subjects consisted of 81 Caucasian undergraduate students (23 male, 58 female) from the University of North Dakota and 98 adult Native Americans (34 male, 64 female) from three different tribal colleges. The sample from Tribe 1 consisted of 54 subjects (14 male, 40 female) out of an approximate student population of 200. The sample from Tribe 2 consisted of 25 subjects (12 male, 13 female) out of an approximate student population of 100. The sample from Tribe 3 consisted of 19 subjects (8 male and 11 female) out of an approximate student population of 125.

Instrumentation

The subjects completed three questionnaires. The first questionnaire (Appendix A) obtained general background information including gender, age, race and years of education completed by the subject and the subject's parents. It also contains questions concerning the degree of personal identification with Christian, Native American, and other spiritual beliefs and practices and includes questions concerning actual involvement in activities relevant to each of these traditions. Two Native American psychologists assisted in the development of the traditionality and Christian spirituality questions

The second questionnaire, the Mental Health Values Questionnaire, is a 99-item instrument which yields scores for eight dimensions for conceptualizing healthy emotional adjustment (Appendix B). The construction of the MHVQ has been described elsewhere (Tyler, Clark, Olson et al, 1983). In brief, the eight MHVQ scales were derived from an initial heterogeneous pool of 236 items contributed by samples of psychiatric inpatients, mental health center directors, and college students who were asked to identify traits indicative of whether "an individual's personal adjustment is good, bad, average, etc." Two different samples of college students were used to construct and then cross-validate the final 99-item, 8-factor version of the MHVQ. The eight scales are Self-Acceptance, Negative Traits, Achievement, Affective Control, Good Interpersonal Relations, Untrustworthiness, Religious Commitment, and Receptivity to Unconventional Experiences.

Responses to each of the items are made on a 5-point rating scale. Respondents are instructed that: "The following statements tell something about a person. Read each statement carefully, and decide whether the statement means that the person has 'good mental health' or 'poor mental health.'" Respondents are then asked to give a rating of 1 if the item indicates "very poor mental health", 2 for "poor mental health", 3 for "neutral, statement is not related to mental health", 4 for "good mental health", and 5 for "very good mental health." Each item consists of a descriptive statement about a hypothetical individual. Thus, for each of the eight dimensions, a

high score indicates that the rater views the behavior depicted to be indicative of good mental health.

A third questionnaire, the Sources of Referral Questionnaire (Tyler & Suan, 1989), contains nine vignettes, each describing a situation in which "someone" the subject knows is having a personal difficulty (Appendix C). Types of personal difficulties consist of: a relationship problem; a child behavior problem; depression, hearing voices from a TV, grieving, hearing voices at night, violent drinking behavior, physical complaints, and experiencing rude behavior. Two Native American psychologists assisted in the development of the two vignettes that involved voices. For each vignette, the subject was required to rate the likelihood of choosing each of seven different options for dealing with the problem. The choices for handling each problem consist of talking with : a spiritual leader, close friend, doctor, work it out on his/her own, relative, mental health professional, older person whom you know. Following the procedure described by Spaulding and Balch (1985), on each problem the subject was also asked to rate the severity of the problem, and indicate whether or not it is a mental health problem, and if it has happened to anyone they know.

Procedure

The Caucasian sample was drawn from undergraduate psychology courses at the University of North Dakota. Subjects were solicited through approaching individual classes and requesting the students to sign up for pre-selected survey times. At the pre-selected time, the project was briefly described as were the

participant's rights as subjects. The questionnaires were then passed out. The Caucasian subjects received extra course credit for their participation.

The Native American samples were drawn from the tribal colleges on the three reservations. A Native American psychologist assisted in the choice of incentive for participation for the Native American college students. For Tribe 1, a tribal college official was approached by the experimenter to request permission to solicit students for participation in the study. The college official arranged a meeting between the College Administrative Board and the experimenter. During the meeting, the Administration members inquired about the nature and purpose of the study. They agreed to allow the experimenter to administer the questionnaires within the classrooms. This permission was given with the stipulation that: 1)Each individual teacher would also have to give permission for his/her class to be utilized in this fashion; 2)the College Administrators would be given the chance to view the results and interpretations before the dissertation is in final form; and 3)the experimenter would present his results to the college and would donate a final copy of the dissertation to the college library. The Administrators also asked that a short questionnaire be distributed which inquired about knowledge of and willingness to use college resources, with the understanding that this questionnaire was purely for the benefit of the college and that it would not be included in the dissertation. A letter from the College Administrators documenting

the permission to engage in research along with the stipulations and agreements was submitted to the Institutional Review Board at the University of North Dakota.

Individual teachers were approached to obtain their permission to utilize class time for the gathering of data. Within each class, the experimenter first introduced himself and then passed out a consent form (Appendix D) and a one-page description of the study (Appendix E). At this time the experimenter also verbally described the project and the rights of subjects, with emphasis on the fact that participation was voluntary. They were also informed that in return for fully participating, they were eligible to win either one of three $20 certificates for the local grocery store or one of five free meal certificates at a local restaurant. Students who chose to remain were given a verbal description of each questionnaire before it was passed out When the questionnaires were collected, they were kept separate from the signed consent forms so that a subject's name could not be associated with questionnaire responses.

For Tribe 2, a tribal college official was approached by the experimenter to request permission to solicit students for participation in the study. The college official informed the experimenter that he would first have to gain permission from a member of the Tribal Cultural Committee to conduct research among tribal members. A member of the Cultural Committee was approached and permission to conduct research was granted with the stipulation that a final copy of the dissertation be donated to the tribal college library. A letter documenting the permission to conduct research among tribal member along with the stipulation

was submitted to the Institutional Review Board at the University of North Dakota.

Following this, a meeting was arranged between the College President and the experimenter, at which time the nature and purpose of the study was explained. The President stated that he would have to consult with the other College Administrators and that the experimentor would be informed of the decision. A few weeks later, a letter was received by the experimenter that stated that the college did not currently allow research to be conducted in the classrooms nor did they allow classroom time to be used to solicit students as participants in research. However, the letter also stated that they would allow the experimenter to solicit students and to administer questionnaires within the confines of the college cafeteria. A letter detailing this arrangement was sent by the College Administrators to the Institutional Review Board of the University of North Dakota.

Small signs, which advertised the study and the dates that the experimenter was available, were posted in the college cafeteria. On the preselected dates, the experimenter approached individual students in the cafeteria to request their participation in the study. The experimenter first introduced himself and his reason for conducting the study. Next a description of the study and a description of participant's rights were given, with the emphasis on the voluntary nature of participation. Each student was also informed that in return for full participation, he/she was eligible to win either one of three $20 certificates for the local grocery store or

one of five free meal certificates at a local restaurant. If the student consented to participate, the questionnaires were given with a brief description of each. When the student was finished, the questionnaires were given to the experimenter with the consent form kept separate from the questionnaires.

For Tribe 3, a tribal college official was approached by the experimenter to request permission to solicit students for participation in the study. The official obtained information from the experimenter concerning the nature and the purpose of the study and stated that the appropriate College Administrators would have to review the information. A few days later the official contacted the experimenter and informed him that permission had been granted to solicit students to participate in the study. The experimenter was also informed that class time could not be used to administer the questionnaire, but that he could, with the professor's permission, enter classes to inform the students of his study. The experimenter was also asked to submit a final copy of the dissertation to the college library. A letter documenting the permission to conduct research with the students was sent by a College Administrator to the Institutional Review Board of the University of North Dakota.

Small signs, which advertised the study and the dates that the experimenter was available, were posted around campus. The experimenter approached individual students at the cafe and the student lounge on campus to request their participation in the study. The experimenter first introduced himself and his reason for conducting the study. Next a description of the study and a

description of participant's rights were given, with the emphasis on the voluntary nature of participation. Each student was also informed that in return for full participation, he/she was eligible to win either one of three $20 certificates for the local grocery store or one of five free meal certificates at a local restaurant. If the student consented to participate, the questionnaires would be given with a brief description of each. When the student was finished, the questionnaires were given to the experimenter with the consent form kept separate from the questionnaires.

Variables for Statistical Analysis

Background Questionnaire: Race, Tribal Membership, Traditionality

Race of the subject was defined as either Native American or Caucasian. Tribal membership was defined as Tribe 1, Tribe 2, or Tribe 3. Traditionality of the subject was defined in two ways: degree of identification with Native American tradition (based on the 7 point rating scale in question #12 on the background questionnaire) and degree of involvement in Native American activities (based on the 7 point rating scale in question #11 on the background questionnaire). For the Multiple Regressions, these variables were treated as continuous variables.

For the MANOVA analyses involving tribal membership, these traditionality variables were divided into discreet levels. Since subject size was fairly small, the variables were divided into two levels. On question #11, rating #4 entails participation in traditional activities from one to three times a month, which implies fairly regular involvement. In contrast, rating #3 entails participation in

activities from seven to ten times a year, which implies fairly irregular involvement. Therefore, the division of the rating scale on question #11 into the two levels of involvement in Native American traditional activities consisted of: 0-3, low level of involvement; 4-6, high level of involvement.

On question #12, the individual rating numbers within the rating scale are less specifically defined than question #11. One way to divide this rating scale would be to divide the extreme high end of the scale (#5 - #6) from the rest of the scale. However, as result of the small sample sizes, this might have lead to small cell sizes for the more traditional level of identification. Moving the cutoff point to #4 would potentially increase the cell size for the more traditional level. Therefore, the division of the rating scale on question #12 into the two levels of identification with Native American traditional beliefs consisted of: 0-3 low degree of identification; 4-6 high degree of identification.

Background Questionnaire: Christian Orientation

Christian orientation was defined in two ways: degree of identification with Christian tradition (based on the 7 point rating scale in question # 13 on the background questionnaire) and degree of involvement in Christian-related activities (based on the 7 point rating scale in question #14 on the background questionnaire). Since these two variables were used only in the Multiple Regressions, they were not divided into separate levels.

Background Questionnaire: Spiritual Tradition

For the MANOVA analyses involving racial identity, Native American traditionality and Christian orientation were combined to examine the potential variance resulting from involvement/identification with a spiritual tradition. Spiritual tradition was assessed using two variables. One variable was the level of involvement in Native American or Christian activities, which was based on a combination of questions #11 and #14 on the background questionnaire. The division of this particular variable was based on the same rationale that was used for the division of question #11. Therefore a rating of 0-3 on both #11 (Native American) and #14 (Christian) indicated low level of involvement in a spiritual tradition. A rating of 4-6 on either #11 or #14 indicated high level of involvement in a spiritual tradition.

The second variable was the level of identification with Native American or Christian traditions, which was based on a combination of questions #12 and #13 on the background questionnaire. The division of this particular variable was based on the same rationale that was used for the division of question #12. Therefore a rating of 0-3 on both #12 (Native American) and #13 (Christian) indicated low degree of identification with a spiritual tradition. A rating of 4-6 on either #12 or #13 indicated high degree of identification with a spiritual tradition.

MHVQ

Mental health values were measured using the MHVQ which yielded eight scales: scale 1 - Self-Acceptance; scale 2 - Negative

Traits; scale 3 - Achievement; scale 4 - Affective Control; scale 5 - Good Interpersonal Relations; scale 6 - Untrustworthiness; scale 7 - Religious Commitment; scale 8 - Receptivity to Unconventional Experiences.

Sources of Referral Questionnaire: Options for Help

The options for help ratings were made on a five point scale (Appendix C) for each of 7 options: option 1 - spiritual leader; option 2 - close friend; option 3 - medical doctor; option 4 - rely on one's own coping skills; option 5 - family members; option 6 - mental health professional; option 7 - older person. A composite options for help score was obtained by averaging these scores over the nine different problem situations.

Sources of Referral Questionnaire: Problem Severity

Problem severity was defined as the subject's rating on the five point degree of severity scale for each problem situation (Appendix C). The problem situations consisted of: problem 1 - relationship difficulty; problem 2 - child discipline problem; problem 3 - depression; problem 4 - voices from TV; problem 5 - grieving; problem 6 - voices at night; problem 7 - violent drinking; problem 8 - physical complaints; problem 9 - rude behavior.

CHAPTER III
RESULTS

Results from the Background Questionnaire (Appendix A) for the three tribal samples is demonstrated in Table 1. For the variables that were measured by ratings, the mean scores depict the average rating for each variable within each sample. Descriptions regarding the ratings will follow the table.

TABLE 1

Demographic Variables for each Tribe

	Tribe 1 (n=54)		Tribe 2 (n=25)		Tribe 3 (n=19)	
	Mean	SD	Mean	SD	Mean	SD
Age	32.10	9.23	30.35	9.52	28.37	9.21
Educ.	3.94	1.13	3.54	1.41	3.72	1.36
Town	1.93	0.91	1.16	0.83	0.92	1.17
Reservation:						
0-10	3.14	1.36	3.27	1.41	3.01	1.77
11-20	3.28	0.93	3.02	1.04	2.83	1.57
21+	3.20	1.05	2.82	1.37	2.86	1.53
Father's Education	3.03	1.58	2.84	1.60	3.35	1.62
Mother's Education	3.54	1.20	3.25	1.44	2.90	1.34
NA partic.	3.05	1.81	2.84	1.67	2.61	1.80
NA identi.	3.91	1.94	4.43	1.3	3.71	1.56
Chr. partic.	2.33	1.99	1.82	2.10	0.74	0.73
Chr. identi.	3.02	2.14	2.84	1.95	1.67	1.40

A one way analysis of variance (ANOVA) was computed for each demographic variable with tribal membership as the

independent variable. The average age of the Native American subjects, across tribes, was 31.00 (SD 9.32), with no significant difference in age between tribes ($F(2,75) = .90$, $p < .41$). The average rating, across tribes, for education was 4.00 (SD 1.34) with no significant difference between tribes ($F(2,75) = .56$, $p < .57$). This indicates that the average amount of education among the Native American subjects was 1 to 2 years of college.

For the variable "size of town during childhood", a significant difference was found between the tribes ($F(2,75) = .10.27$, $p < .001$). For this variable, rating #1 indicates a town population of 1,000 to 9,000 and rating #2 indicates a town population of 10,000 to 100,000. A t-test was conducted to analyze the differences between the tribes. Since the follow-up t test comparisons required analyzing a series of three t tests for each variable, a Bonferroni alpha was computed to maintain a family-wise alpha level of .05. The new alpha level (.02) was computed by dividing .05 by 3. On the average, respondents from Tribe 1 had a rating that was significantly higher than Tribe 2 ($t(77) = 4.22$, $p < .001$) and Tribe 3 ($t(71) = 2.68$, $p < .009$). No significant difference was found between Tribe 2 and Tribe 3 ($t(42) = -.36$, $p < .723$). This indicates that, on the average, the participants from Tribe 1 grew up in towns that were equal to or greater than 10,000, whereas the participants from Tribe 2 and Tribe 3 grew up in towns that were smaller than 10,000.

The average rating, across tribes, for amount of time spent on the reservation from age 0-10 yrs was 3.00 (SD 1.4), with no significant difference between tribes ($F(2,75) = .05$, $p < .95$). This

indicates that, on the average, the Native American subjects spent 75% of their life, between the age of 0-10 yrs, on the reservation.

The average rating, across tribes, for amount of time spent on the reservation from age 11-21 was 3 (SD 1.03), with no significant difference between tribes ($F(2,75) = .1.00$, $p < .37$). This indicates that, on the average, the Native American subjects spent 75% of their life, between the age of 11-21 yrs, on the reservation.

The average rating, across tribes, for amount of time spent on the reservation from age 21 and older was 3 (SD 1.24), with no significant difference between tribes ($F(2,75) = ..85$, $p < .43$). This indicates that, on the average, the Native American subjects spent 75% of their life, from age 21 and older, on the reservation.

The average rating, across tribes, for amount of father's education was 3 (SD 1.52) with no significant difference between tribes ($F(2,75) = .45$, $p < .64$). This indicates that the average amount of education among the fathers of Native American subjects was 10 to 12 years of school. The average rating, across tribes, for amount of mother's education was 3 (SD 1.35) with no significant difference between tribes ($F(2,75) = .1.16$, $p < .32$). This indicates that the average amount of education among the mothers of Native American subjects was 10 to 12 years of school.

The average rating, across tribes, for degree of participation in traditional Native American activities was 2.9 (SD 1.83), with no significant difference between tribes ($F(2,95) = .32$, $p < .73$). This indicates that, on the average, the Native American sample

participated in traditional Native American activities at least seven to ten times a year.

The average rating, across tribes, for degree of identification with traditional Native American beliefs was 4 (SD 1.71) with no significant difference between tribes ($F(2,95) = .91$, $p < .41$). For this question, subjects were asked to rate their degree of identification in Native American traditional beliefs on a scale of 0 to 6, with 0 indicating no identification to 6 indicating complete identification. Therefore a rating of 4 indicates, on the average, a fairly strong identification with Native American traditions among the participants.

Differences among the tribes were found for degree of participation in Christian church related activities ($F(2,95) = 5.51$, $p < .005$). A t-test was conducted to analyze the differences between the tribes. Since the follow-up t test comparisons required analyzing a series of three t tests for each variable, a Bonferroni alpha was computed to maintain a family-wise alpha level of .05. The new alpha level (.02) was computed by dividing .05 by 3. On the average, participants from Tribe 3 participated less frequently in Christian activities than participants from Tribe 1 ($t(71) = 3.47$, $p < .001$) with a similar difference between Tribe 3 and Tribe 2 that approached significance ($t(42) = 2.22$, $p < .03$). No significant difference was found between Tribe 1 and Tribe 2 ($t(77) = 1.05$, $p < .30$). This indicates that, on the average, participants from Tribe 1 and Tribe 2 participate in Christian activities four to six times a year, whereas,

respondents from Tribe 3 participate in Christian activities one to three times a year.

Differences among the tribes were found for degree of identification in Christian beliefs ($F(2,95) = 3.94$, $p < .02$). A t-test was conducted to analyze the differences between the tribes. Since the follow-up t test comparisons required analyzing a series of three t tests for each variable, a Bonferroni alpha was computed to maintain a family-wise alpha level of .05. The new alpha level (.02) was computed by dividing .05 by 3. On the average, respondents from Tribe 3 identified less with Christian traditions than respondents from Tribe 1 ($t(71) = 2.78$, $p < .007$) and respondents from Tribe 2 ($t(42) = 2.37$, $p < .02$). No significant difference was found between Tribe 1 and Tribe 2 ($t(77) = .33$, $p < .75$). This indicates that, on the average, respondents from Tribe 1 and Tribe 2 experienced a fair degree of identification with Christian traditions, whereas respondents from Tribe 3 indicated a smaller degree of identification with Christian traditions.

A Chi-square analysis indicated that significantly more participants from Tribe 1 (27) than participants from Tribe 2 (20) had sought the services of a mental health professional ($X2(1, N=79) = 6.8$, $p < .009$). A second Chi-square analysis indicated that no significant difference existed between Tribe 1 and Tribe 2 in the number of participants who had family members that sought professional mental health services ($X2(1, N=79) = 1.1$, $p < .60$).

A Chi-square analysis indicated that significantly more participants from Tribe 1 (27) than participants from Tribe 3 (16)

had sought the services of a mental health professional ($X_2(1, N=73) = 7.4, p < .006$). A second Chi-square analysis indicated that no significant difference existed between Tribe 1 and Tribe 3 in the number of participants who had family members that sought professional mental health services($X_2(1, N=73) = 3.2, p < .07$).

A Chi-square analysis indicated that no significant difference existed between Tribe 2 and Tribe 3 in the number of participants who sought professional mental health services ($X_2(1, N=44) = 13, p < .72$). A second Chi-square analysis indicated no significant difference between Tribe 2 and Tribe 3 in the number of participants who had family members that sought professional mental health services ($X_2(1, N=44) = 1.7, p < .19$).

TABLE 2

Demographic Variables for Caucasians and Native Americans

	Native Americans (n=98)		Caucasians (n=81)	
	Means	SD	Means	SD
Age	29.13	9.64	21.32	4.85
Educ.	3.73	1.35	4.10	0.76
Town	1.57	0.97	2.23	1.38
Father's Education	3.12	1.54	4.57	1.36
Mother's Education	3.43	1.26	4.22	1.20
NA parti.	2.90	1.83	0.14	0.42
NA ident.	3.97	1.73	0.32	0.67
Chr. parti.	1.94	1.92	3.31	1.74
Chr. ident	2.76	1.98	4.17	1.71

Background data for the Caucasian and Native American subjects is displayed in Table 2. The means and standard deviations

for the Caucasian sample and the Native American sample are shown for age, amount of education, size of town during childhood, amount of father's education, and amount of mother's education. The mean scores for the variable "age" indicates the average age of the sample. For the other variables, however, the mean scores depict the average rating for each variable within each sample.

A one way analysis of variance (ANOVA) was completed for each demographic variable with race of subject as the independent variable. Native American participants were significantly older than Caucasian participants ($F(1,174) = 44.30$, $p < .001$). A significant difference was found for level of education ($F(1,174) = 6.17$, $p < .01$). On the average, Native Americans reported receiving 10-12 years of education, whereas Caucasians reported receiving 1-2 years of college. Caucasian participants grew up in towns that were significantly larger than the towns that the Native American participants grew up in ($F(1,174) = 16.44$, $p < .001$). On the average, the Native American participants grew up in towns with population ranging from 1,000 to 10,000 as compared to the Caucasian participants who grew up in towns with populations of 10,000 or more people.

The fathers of Caucasians had a significantly higher level of education than the fathers of Native Americans ($F(1,174) = 38.18$, $p < .001$). On the average, the fathers of the Caucasian participants had three to five years of college education, and the fathers of the Native American participants had 10-12 years of schooling.

The mothers of the Caucasian participants had a significantly higher level of education than the mothers of the Native American participants ($F(1,174) = 23.32$, $p < .001$). On the average, the mothers of the Caucasian participants had one to two years of college and the mothers of the Native American participants had 10 to 12 years of schooling.

The Native American respondents indicated a significantly higher degree of participation in traditional Native American activities than the Caucasian respondents ($F(1,177) = 192.9$, $p < .001$). On the average, Native American respondents participated in Native American activities seven to ten times a year, whereas the Caucasian respondents participated 0 to 1 time a year.

The Native American respondents also indicated a significantly higher degree of identification with Native American traditions than the Caucasian respondents ($F(1,177) = 335.3$, $p < .001$). On the average, the Native American students express a fairly high degree of identification with their traditions, whereas the Caucasian students indicate almost no identification with these traditions.

The Caucasian students indicated a significantly higher degree of participation in Christian-related activities than the Native American students ($F(1,177) = 26.7$, $p < .001$). On the average, the Caucasian students participated in Christian church activities seven to ten times a year, whereas the Native American students participated in Christian church activities four to six times a year.

The Caucasian students also indicated a significantly higher degree of identification with Christian beliefs than the Native

American students ($F(1,177) = 26.7$, $p < .001$). On the average, the Caucasian students expressed a fairly high degree of identification with the Christian beliefs, whereas the Native Americans expressed a fairly low degree of identification with Christian beliefs.

A Chi-square analysis indicated that significantly more Native American participants (63) than Caucasian participants (29) had sought the services of a mental health professional ($X_2(1, N=179) = 14.59$, $p < .001$). A second Chi-square analysis indicated that significantly more Native American participants (65) than Caucasian participants (34) had family members who had sought the services of a mental health professional ($X_2(1, N=179) = 3.82$, $p < .05$).

MHVQ: Tribe X Gender

A 3(tribal membership) by 2(gender) Multivariate Analysis of Variance (MANOVA) was computed with the eight scales of the Mental Health Values Questionnaire (MHVQ) as the dependent variables. The multivariate F (.14) for the main effect of gender was nonsignificant ($p = .33$). Table 3 depicts the mean ratings on the MHVQ scales for each gender. The multivariate F (.20) for the interaction effect was nonsignificant ($p = .71$). Table 4 depicts the mean ratings on the MHVQ scales for each gender within each tribal group. The multivariate F (.49) for the main effect of tribal membership was significant ($p < .01$). For the follow-up ANOVAs, a Bonferroni alpha of .006 was derived by dividing .05 by the number of MHVQ scales (8). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, a significant tribal membership effect was found for the MHVQ

scale of religious commitment. Table 5 depicts the mean ratings on the MHVQ scales for each tribal group. Follow up t-tests were conducted to analyze the differences between the tribes. Since the follow-up t test comparisons required analyzing a series of three t tests, a Bonferroni alpha was computed to maintain a family-wise alpha level of .05. The new alpha level (.02) was computed by dividing .05 by 3.

TABLE 3

MHVQ Scale Scores For Each Gender

MHVQ Scale	Male Mean	SD	Female Mean	SD	F	p
Self-Accep.	3.89	0.44	4.12	0.45	4.57	.04
Neg. Trait	2.49	0.45	2.27	0.43	4.52	.04
Achiev.	3.59	0.48	3.67	0.42	0.59	.44
Affec. Con.	3.32	0.49	3.18	0.39	1.48	.23
Relation	3.91	0.43	4.13	0.43	3.75	.06
Untrust.	2.04	0.38	1.87	0.44	3.55	.06
Religious	3.91	0.31	3.99	0.36	0.79	.38
Unconv.	2.72	0.48	2.89	0.53	2.03	.16

df for all analyses = 1,81

Participants from Tribe 1 (4.13) ($t(62) = 4.4$, $p < .001$) and Tribe 2 (4.08) ($t(41) = 3.9$, $p < .001$) perceived religious commitment to be more relevant to good mental health than did participants from Tribe 3 (3.66). No significant difference was found between Tribe 1 and Tribe 2 for religious commitment ($t(67) = .45$, $p < .67$).

TABLE 4

MHVQ Scale Scores For Each Gender by Tribal Group

MHVQ Scales	Tribe 1 Male Mn, SD	Tribe 1 Female Mn, SD	Tribe 2 Male Mn, SD	Tribe 2 Female Mn, SD	Tribe 3 Male Mn, SD	Tribe 3 Female Mn, SD	F	p
Self-Accep.	4.07 .43	4.16 .50	3.98 .46	4.15 .47	3.64 .27	4.06 .38	0.78	.46
Neg. Trait	2.41 .49	2.25 .45	2.39 .46	2.25 .43	2.68 .29	2.32 .38	0.39	.68
Achiev.	3.75 .45	3.70 .48	3.72 .51	3.78 .39	3.29 .24	3.52 .31	0.58	.56
Affec. Con.	3.59 .56	3.31 .50	3.31 .40	3.16 .28	3.05 .51	3.06 .50	0.58	.56
Relation	4.17 .51	4.15 .49	4.05 .56	4.17 .44	3.52 .30	4.06 .42	2.03	.14
Untrust.	1.86 .42	1.82 .36	2.12 .32	1.92 .46	2.15 .34	1.88 .40	0.61	.55
Religious	4.10 .44	4.13 .43	4.04 .41	4.12 .41	3.58 .13	3.73 .31	0.13	.88
Unconv.	2.82 .62	2.90 .50	3.02 .37	2.77 .58	2.32 .53	3.01 .47	2.25	.08

df for all analyses = 2,81

TABLE 5

MHVQ Scale Scores For Each Tribal Group

MHVQ Scale	Tribe 1 Mean	SD	Tribe 2 Mean	SD	Tribe 3 Mean	SD	F	p
Self-Accep.	4.11	.48	4.06	.46	3.84	.39	2.23,	.12
Neg. Trait	2.32	.46	2.32	.44	2.50	.38	1.31,	.33
Achiev.	3.72	.47	3.75	.45	3.40	.30	4.04,	.02
Affec. Con.	3.45	.53	3.23	.35	3.05	.49	4.41,	.02
Relation.	4.16	.49	4.11	.50	3.79	.46	3.76,	.03
Untrust.	1.84	.38	2.02	.40	2.01	.39	2.00,	.13
Religious	4.12	.42	4.08	.40	3.66	.25	9.02,	.001
Unconv.	2.86	.53	2.89	.49	2.67	.60	1.21,	.32

df for all variables = 2,84

MHVQ: Tribe X Level of Native American Involvement

A 3(tribal membership) by 2(level of involvement in Native American activities) Multivariate Analysis of Variance (MANOVA)

was performed with the eight scales of the Mental Health Values Questionnaire (MHVQ) as dependent variables. The multivariate F (1.19) for the main effect of level of Native American involvement was nonsignificant (p = .32). Table 6 depicts the mean rating on the MHVQ scales for each level of Native American involvement. The multivariate F (.91) for the interaction effect was nonsignificant (.54). Table 7 depicts the mean ratings on the MHVQ scales for each level of Native American involvement within each tribal group. The multivariate F for the main effect of tribal membership was identical to the Tribe by Gender analysis.

TABLE 6

MHVQ Scale Scores For Each Level of Native American Involvement

MHVQ Scale	Level 1 Mean	SD	Level 2 Mean	SD	F	p
Self-Accep.	4.04	.45	3.96	.41	0.53	.47
Neg. Trait	2.35	.44	2.42	.42	0.43	.52
Achiev.	3.64	.39	3.59	.38	0.18	.67
Affec. Con.	3.24	.38	3.19	.51	0.20	.66
Relation	4.12	.48	3.85	.42	4.83	.03
Untrust.	1.91	.40	2.05	.34	2.35	.13
Religious	3.96	.38	3.93	.31	0.10	.75
Unconv.	2.79	.54	2.84	.49	0.14	.71

df for all analyses = 1,81

MHVQ: Tribal X Native American Identification

A 3(tribal membership) by 2(level of identification with Native American beliefs) Multivariate Analysis of Variance (MANOVA) was

performed with the eight scales of the Mental Health Values Questionnaire (MHVQ) as dependent variables.

TABLE 7

MHVQ Scale Scores For Each Level of Native American Involvement by Tribal Group

MHVQ Scales	Tribe 1 Lv 1 Mn, SD	Tribe 1 Lv 2 Mn, SD	Tribe 2 Lv 1 Mn, SD	Tribe 2 Lv 2 Mn, SD	Tribe 3 Lv 1 Mn, SD	Tribe 3 Lv 2 Mn, SD	F	p
Self-Accep.	4.07 .47	4.25 .48	4.12 .49	3.97 .42	3.94 .41	3.67 .29	1.77	.18
Neg. Trait	2.30 .42	2.26 .54	2.33 .48	2.31 .38	2.40 .38	2.69 .33	0.82	.44
Achiev.	3.68 .49	3.78 .44	3.75 .44	3.74 .49	3.48 .29	3.25 .26	0.79	.46
Affec. Con.	3.44 .54	3.31 .50	3.20 .26	3.29 .47	3.09 .46	2.96 .61	0.42	.66
Relation	4.14 .49	4.18 .50	4.22 .52	3.92 .42	3.97 .43	3.46 .30	2.21	.12
Untrust.	1.88 .38	1.76 .36	1.96 .45	2.14 .30	1.90 .37	2.26 .36	2.59	.08
Religious	4.10 .41	4.16 .45	4.09 .46	4.06 .31	3.69 .27	3.58 .17	0.30	.74
Unconv.	2.72 .52	3.15 .43	2.82 .55	3.01 .38	3.84 .54	2.36 .66	1.71	.19

df for all analyses = 2,81

TABLE 8

MHVQ Scale Scores For Each Level of Native American Identification

MHVQ Scale	Level 1 Mean	SD	Level 2 Mean	SD	F	p
Self-Accep.	3.99	.35	4.03	.47	0.13	.72
Neg. Trait	2.35	.48	2.38	.39	0.05	.82
Achiev.	3.63	.35	3.61	.39	0.03	.86
Affec. Con.	3.21	.42	3.22	.47	0.00	.95
Relation	4.11	.38	3.97	.51	1.36	.25
Untrust.	1.90	.40	1.98	.38	0.81	.37
Religious	3.93	.40	3.97	.33	0.14	.71
Unconv.	2.82	.48	2.82	.57	0.00	.98

df for all analyses = 1,81

The multivariate F (.87) for the level of Native American identification main effect was nonsignificant (p = .56). Table 8 depicts the mean ratings on the MHVQ scales for each level of Native American identification. The multivariate F (.74) for the interaction effect was nonsignificant (p = .77). Table 9 depicts the mean ratings on the MHVQ scales for each level of Native American identification within each tribal group. The multivariate F for the main effect of tribal membership was identical to the one obtained in the Tribe by Gender analysis.

TABLE 9

MHVQ Scale Scores For Each Level of Native American Identification by Tribal Group

MHVQ Scales	Tribe 1 Lv 1 Mn, SD	Tribe 1 Lv 2 Mn, SD	Tribe 2 Lv 1 Mn, SD	Tribe 2 Lv 2 Mn, SD	Tribe 3 Lv 1 Mn, SD	Tribe 3 Lv 2 Mn, SD	F	p
Self-Accep.	4.07 .53	4.18 .44	3.74 .27	4.12 .52	3.97 .27	3.79 .46	0.83	.44
Neg. Trait	2.33 .35	2.26 .53	2.35 .62	2.31 .37	2.38 .48	2.58 .28	0.59	.56
Achiev.	3.67 .51	3.75 .44	3.64 .26	3.19 .50	3.58 .29	3.29 .24	1.52	.22
Affec. Con.	3.35 .61	3.41 .47	3.14 .30	3.27 .37	3.15 .36	2.98 .58	0.49	.61
Relation	4.13 .51	4.17 .48	4.16 .29	4.09 .57	4.03 .33	3.66 .49	1.17	.32
Untrust.	1.93 .40	1.76 .35	1.91 .42	2.06 .40	1.85 .37	2.12 .38	2.65	.08
Religious	4.05 .43	4.18 .42	4.04 .43	4.10 .40	3.70 .34	3.63 .16	0.43	.66
Unconv.	2.75 .53	2.97 .52	2.84 .40	2.92 .54	2.86 .51	2.58 .66	1.14	.25

df for all analyses = 2,81

MHVQ: Racial Identity by Gender

A 2(racial identity) by 2(gender) Multivariate Analysis of Variance (MANOVA) was performed with the eight scales of the Mental Health Values Questionnaire (MHVQ) as dependent variables. The multivariate F (2.31) for the main effect of gender was

significant ($p < .02$). For the follow-up ANOVAs, a Bonferroni alpha of .006 was derived by dividing .05 by the number of MHVQ scales (8). This was done to maintain a family wise alpha level of .05 and to guard against Type I error.

TABLE 10

MHVQ Scale Scores For Each Gender

MHVQ	Male		Female			
	Mean	SD	Mean	SD	F	p
Self-Accep.	4.03	.40	4.18	.44	4.92	.03
Neg. Trait	2.53	.49	2.44	.36	1.90	.17
Achiev.	3.71	.52	3.64	.43	0.93	.35
Affec. Con.	3.49	.45	3.36	.42	3.16	.08
Relation.	4.05	.46	4.14	.44	1.22	.27
Untrust.	1.96	.31	1.92	.36	0.54	.47
Religious	4.05	.42	4.00	.47	0.41	.55
Unconv.	2.64	.58	2.75	.57	1.13	.29

df for all analyses = 1,164

Based upon this alpha level, no significant gender effect was found for any specific MHVQ scale. Table 10 depicts the mean ratings on the MHVQ scales for each gender. The multivariate F (.84) for the interaction effect was nonsignificant ($p = .58$). Table 11 depicts the mean ratings on the MHVQ scales for each gender within each racial group. The multivariate F (5.44) for the main effect of race was significant ($p < .01$). For the follow-up ANOVAs, a Bonferroni alpha of .006 was derived by dividing .05 by the number of MHVQ scales (8). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, significant main effects for racial identity were found for

negative traits , affective control , and receptivity to unconventional experiences.

TABLE 11

MHVQ Scale Scores For Each Gender by Racial Group

MHVQ Scales	Native American Male Mn, SD	Native American Female Mn, SD	Caucasian Male Mn, SD	Caucasian Female Mn, SD	F	p
Self-Accep.	3.93 .43	4.14 .47	4.13 .36	4.23 .41	0.63	.43
Neg. Trait	2.47 .44	2.26 .43	2.60 .53	2.62 .32	2.77	.10
Achiev.	3.62 .47	3.69 .44	3.79 .57	3.59 .42	3.09	.08
Affec. Con.	3.35 .32	3.23 .47	3.63 .40	3.49 .38	0.04	.85
Relation	3.96 .54	4.14 .41	4.13 .41	4.13 .41	1.67	.20
Untrust.	2.03 .38	1.85 .39	1.89 .39	1.98 .35	2.56	.12
Religious	3.95 .42	4.06 .43	4.15 .43	3.95 .52	2.79	.10
Unconv.	2.77 .57	2.89 .51	2.52 .60	2.60 .63	0.05	.83

df for all analyses = 1,164

TABLE 12

MHVQ Scale Scores For Each Race

MHVQ	Native American Mean	SD	Caucasian Mean	SD	F	p
Self-Accep.	4.03	.44	4.18	.40	4.42	.04
Neg. Trait	2.37	.43	2.61	.45	12.75	.001
Achiev.	3.65	.46	3.69	.49	0.21	.66
Affec. Con.	3.29	.51	3.56	.39	13.00	.001
Relation	4.05	.52	4.14	.41	1.41	.24
Untrust.	1.94	.38	1.93	.29	0.03	.86
Religious	4.01	.42	4.05	.47	7.44	.54
Unconv.	2.83	.54	2.56	.60	8.26	.005

df for all analyses = 1,164

Native American respondents (2.37) viewed negative traits as a stronger criterion of poor mental health than did Caucasian respondents (2.61). Native American respondents (3.29) were less

likely than Caucasian respondents (3.56) to view affective control as a criterion of good mental health. Native American respondents (2.83) were more accepting of unconventional experiences than Caucasian respondents (2.56). Table 12 depicts the mean ratings on the MHVQ scales for each racial group.

MHVQ: Race X Level of Spiritual Involvement

A 2(racial identity) by 2(level of involvement in a spiritual tradition) Multivariate Analysis of Variance (MANOVA) was performed with the eight scales of the Mental Health Values Questionnaire (MHVQ) as dependent variables.

TABLE 13

MHVQ Scale Scores For Each Level of Spiritual Involvement

MHVQ	Level 1		Level 2			
	Mean	SD	Mean	SD	F	p
Self-Accep	4.09	.43	4.18	.44	2.13	.15
Neg. Trait	2.44	.38	2.51	.45	1.91	.28
Achiev.	3.60	.42	3.70	.47	2.04	.16
Affec. Con.	3.38	.46	3.43	.45	0.55	.48
Relation.	4.06	.44	4.15	.47	1.83	.18
Untrust.	1.92	.37	1.95	.35	0.36	.57
Religious	3.94	.45	4.08	.49	3.52	.06
Unconv.	2.60	.56	2.82	.57	6.30	.01

df for all analyses = 1,164

The multivariate F (2.68) for the main effect of level of spiritual involvement was significant ($p < .01$). For the follow-up ANOVAs, a Bonferroni alpha of .006 was derived by dividing .05 by the number of MHVQ scales (8). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, no significant main effects of level of spiritual

involvement were found for any specific MHVQ scale. Table 13 depicts the mean ratings on the MHVQ scales for each level of spiritual involvement. The multivariate F (1.55) for the interaction effect was nonsignificant (p = .14). Table 14 depicts the mean ratings on the MHVQ scales for each level of spiritual involvement within each racial group. The multivariate F for the main effect of racial identity was identical to the Race by Gender analysis.

TABLE 14
Mean Ratings on MHVQ Scales For Each Level of Spiritual Involvement by Racial Group and the Associated df, F, & p values

MHVQ Scales	Native American Level 1 Mn, SD	Native American Level 2 Mn, SD	Caucasian Level 1 Mn, SD	Caucasian Level 2 Mn, SD	F	p
Self-Accep.	3.97 .44	4.14 .47	4.19 .40	4.21 .40	1.29	.26
Neg. Trait	2.36 .41	2.31 .47	2.52 .39	2.70 .39	3.44	.07
Achiev.	3.57 .41	3.75 .46	3.63 .51	3.65 .51	1.34	.25
Affec. Con.	3.25 .48	3.31 .50	3.51 .39	3.55 .39	0.02	.89
Relation	4.03 .46	4.11 .53	4.08 .42	4.19 .42	0.04	.84
Untrust.	1.94 .40	1.90 .39	1.90 .29	2.00 .29	1.50	.22
Religious	3.94 .38	4.09 .45	3.95 .53	4.06 .53	0.06	.81
Unconv.	2.73 .50	2.96 .54	2.46 .63	2.68 .63	0.00	.98

df for all analyses = 1,164

MHVQ: Racial Identity X Level of Spiritual Identification

A 2(racial identity) by 2(level of identification with a spiritual tradition) Multivariate Analysis of Variance (MANOVA) was performed with the eight scales of the Mental Health Values Questionnaire (MHVQ) as the dependent variables. The multivariate F (1.69) for the main effect of level of spiritual identification was not

significant (p = .10). Table 15 depicts the mean ratings on the MHVQ scales for each level of spiritual identification.

TABLE 15

MHVQ Scale Scores For Each Level of Spiritual Identification

MHVQ	Level 1 Mean	SD	Level 2 Mean	SD	F	p
Self-Accep	4.07	.40	4.15	.44	1.28	.26
Neg. Trait	2.47	.40	2.48	.42	0.04	.85
Achiev.	3.65	.46	3.65	.46	0.02	.88
Affec. Con.	3.38	.46	3.41	.43	0.19	.66
Relation.	4.11	.42	4.10	.46	0.12	.89
Untrust.	1.92	.37	1.94	.35	0.09	.77
Religious	4.02	.41	4.00	.48	0.07	.79
Unconv.	2.70	.55	2.72	.59	0.03	.86

df for all analyses = 1,164

TABLE 16

MHVQ Scale Scores For Each Level of Spiritual Identification by Racial Group

MHVQ Scales	Native American Level 1 Mn, SD		Native American Level 2 Mn, SD		Caucasian Level 1 Mn, SD		Caucasian Level 2 Mn, SD		F	p
Self-Accep.	3.90	.40	4.11	.47	4.24	4.24	4.18	.40	3.50	.06
Neg. Trait	2.39	.43	2.32	.45	2.55	2.55	2.65	.39	1.31	.25
Achiev.	3.60	.40	3.69	.46	3.69	3.69	3.62	.46	1.03	.31
Affec. Con.	3.23	.50	3.30	.49	3.53	3.53	3.53	.38	0.25	.62
Relation	4.06	.43	4.08	.52	4.16	4.16	4.12	.41	0.11	.75
Untrust.	1.93	.39	1.91	.40	1,91	1.91	1.97	.31	0.38	.54
Religious	3.91	.37	4.05	.44	4.05	4.13	3.94	.52	2.14	.15
Unconv.	2.83	.44	2.86	.56	2.86	2.57	2.58	.61	1.75	.19

df for all analyses = 1,164

The multivariate F for the interaction effect was nonsignificant.

Table 16 depicts the mean ratings on the MHVQ scales for each level

of spiritual identification within each racial group. The multivariate F for the main effect of racial identity was identical to the Race by Gender analysis.

TABLE 17

Options For Help Ratings for Each Gender

Options	Male Mean	SD	Female Mean	SD	F	p
Spiritual	3.40	.93	3.45	.93	0.04	.85
Friend	3.57	.97	3.58	.73	0.00	.99
Doctor	3.42	.83	3.49	.66	0.14	.71
On Own	2.41	.99	2.29	.99	0.27	.60
Family	3.66	.94	3.59	.77	0.08	.78
Mental	3.65	.92	4.08	.59	5.03	.03
Older Per.	3.68	.92	3.43	.89	1.20	.28

df for all analyses = 1,68

TABLE 18

Options for Help Ratings For Each Gender by Tribal Group

Options	Tribe 1 Male Mn, SD	Tribe 1 Female Mn, SD	Tribe 2 Male Mn, SD	Tribe 2 Female Mn, SD	Tribe 3 Male Mn, SD	Tribe 3 Female Mn, SD	F	p
Spiritual	3.82 .99	3.73 .90	3.73 .85	3.68 .80	2.67 .80	2.94 .99	0.22	.81
Friend	3.66 .98	3.72 .85	3.49 .99	3.68 .75	3.57 .93	3.33 .59	0.29	.75
Doctor	3.31 .99	3.36 .76	3.63 .77	3.76 .54	3.32 .74	3.36 .67	0.02	.98
On Own	2.31 .99	2.33 .89	2.57 .99	2.35 .99	2.38 .80	2.17 .74	0.10	.90
Family	3.69 .99	3.84 .82	3.63 .94	3.53 .99	3.65 .82	3.42 .46	0.30	.74
Mental	3.40 .99	3.74 .74	4.07 .75	4.50 .55	3.46 .83	4.03 .47	0.12	.88
Older Per.	3.97 .69	3.78 .80	3.69 .99	3.56 .99	3.38 .99	2.96 .74	0.12	.88

df for all analyses = 2,68

OPTIONS FOR HELP: Tribe X Gender

A 3(tribal membership) by 2(gender) Multiple Analysis of Variance (MANOVA) was performed with the 7 options for help,

averaged across problem situations, as the dependent variables. The multivariate F (1.50) for the main effect of gender was nonsignificant (p = .18). Table 17 depicts the mean ratings on the options for help for each gender. The multivariate F (.24) for the interaction effect was nonsignificant (p = .99).

TABLE 19

Options for Help Ratings For Each Tribal Group

Options	Tribe 1		Tribe 2		Tribe 3			
	Mean	SD	Mean	SD	Mean	SD	F	p
Spiritual	3.69	.97	3.71	.80	2.81	.90	6.53	.003
Friend	3.69	.90	3.59	.90	3.45	.80	0.42	.66
Doctor	3.33	.80	3.69	.60	3.34	.70	1.57	.23
On Own	2.32	.90	2.46	1.3	2.27	.75	0.18	.84
Family	3.76	.89	3.58	.96	3.54	.64	0.47	.63
On Own	3.63	.88	4.3	.67	3.76	.71	5.20	.01
Older Per.	3.84	.76	3.62	1.1	3.16	.89	3.41	.04

df for all analyses = 1,151

Table 18 depicts the mean ratings on the options for help for each gender within each tribal group. The multivariate F (1.82) for the main effect of tribal membership was significant (p < .04). For the follow-up ANOVAs, a Bonferroni alpha of .007 was derived by dividing .05 by the number of options (7). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, a significant tribal membership effect was found for spiritual leader. Table 19 depicts the mean ratings on the options for help for each tribal group. Since the follow-up t test comparisons required analyzing a series of three t tests, a Bonferroni

alpha was computed to maintain a family-wise alpha level of .05. The new alpha level (.02) was computed by dividing .05 by 3.

When averaging the rating of the solutions across problem situations, participants from Tribe 1 (3.69) ($t(54) = 3.0$, $p < .001$) and Tribe 2 (3.71) ($t(37) = 3.3$, $p < .001$) were more likely to recommend a spiritual leader than participants from Tribe 3 (2.81). A significant difference between Tribe 1 and Tribe 2 was not found for this option ($t(59) = -.12$, $p < .90$).

TABLE 20

Options for Help Ratings For Each Level of Native American Involvement

Options	Level 1 Mean	SD	Level 2 Mean	SD	F	p
Spiritual	3.42	.98	3.44	.83	0.01	.92
Friend	3.58	.81	3.57	.88	0.00	.95
Doctor	3.51	.69	3.37	.83	0.52	.47
On Own	2.27	.99	2.48	.91	0.66	.42
Family	3.52	.79	3.80	.65	1.61	.21
Mental	4.02	.70	3.68	.69	2.77	.10
Older Per.	3.42	.98	3.77	.92	2.35	.13

df for all analyses = 1,68

OPTIONS FOR HELP: Tribe X Level of Native American Involvement

A 3(tribal membership) by 2(level of involvement in Native American activities) Multiple Analysis of Variance (MANOVA) was performed with the 7 options for help, averaged across problem situations, as the dependent variables. The multivariate F (1.06) for the main effect of level of Native American involvement was

nonsignificant (p = .40). Table 20 depicts the mean ratings on the options for help for each level of Native American involvement.

TABLE 21

Options for Help Ratings For Each Level of Native American Involvement by Tribal Group

Options	Tribe 1		Tribe 2		Tribe 3			
	Lv 1	Lv 2	Lv 1	Lv 2	Lv 1	Lv 2		
	Mn, SD	Mn, SD	Mn, SD	Mn, SD	Mn, SD	Mn, SD	F	p
Spiritual	3.72 .99	3.81 .87	3.75 .86	3.63 .76	2.78 .99	2.89 .86	0.09	.91
Friend	3.68 .72	3.73 .99	3.56 .99	3.65 .60	3.50 .70	3.31 .94	0.13	.88
Doctor	3.33 .80	3.37 .89	3.81 .49	3.54 .83	3.40 .77	3.20 .44	0.29	.75
On Own	2.28 .99	2.39 .80	2.33 .99	2.63 .99	2.19 .80	2.44 .82	0.06	.94
Family	3.79 .70	3.79 .99	3.29 .99	4.00 .62	3.49 .58	3.62 .85	1.11	.34
Mental	3.57 .95	3.74 .80	4.61 .41	3.85 .74	3.88 .75	3.47 .54	2.45	.09
Older Per.	3.77 .75	3.93 .73	3.54 .99	3.74 .96	2.95 .76	3.64 .99	0.48	.62

df for all analyses = 2,68

TABLE 22

Options for Help Ratings For Each Level of Native American Identification

Option	Level 1		Level 2			
	Mean	SD	Mean	SD	F	p
Spiritual	3.43	.90	3.42	.86	0.03	.981
Friend	3.46	.74	3.64	.88	0.65	.426
Doctor	3.61	.71	3.41	.75	1.03	.317
On Own	2.20	.84	2.40	.86	0.68	.458
Family	3.30	.81	3.76	.86	4.12	.046
Mental	4.17	.51	3.78	.83	3.41	.070
Older Per.	3.29	.88	3.64	.87	2.27	.143

df for all analyses = 1,68

The multivariate F (.65) for the interaction effect was nonsignificant (p = .82). Table 21 depicts the mean ratings on the

options for help for each level of Native American involvement within each tribal group. The multivariate F the main effect tribal membership was identical to the Tribe by Gender analysis.

TABLE 23

Options for Help Ratings For Each Level of Native American Identification by Tribal Group

Options	Tribe 1		Tribe 2		Tribe 3			
	Lv 1	Lv 2	Lv 1	Lv 2	Lv 1	Lv 2		
	Mn, SD	Mn, SD	Mn, SD	Mn, SD	Mn, SD	Mn, SD	F	p
Spiritual	3.77 .99	3.75 .97	3.80 .80	3.67 .83	2.72 .99	2.86 .80	0.08	.92
Friend	3.64 .68	3.73 .99	3.53 .85	3.62 .89	3.20 .71	3.58 .78	0.16	.85
Doctor	3.34 .62	3.35 .94	4.02 .48	3.59 .66	3.46 .84	3.27 .61	0.46	.63
On Own	2.22 .97	2.39 .92	2.04 .99	2.59 .99	2.33 .69	2.23 .81	0.39	.68
Family	3.71 .70	3.84 .99	2.84 .99	3.82 .84	3.35 .52	3.63 .71	1.33	.27
Mental	3.68 .75	3.61 .97	4.67 .33	4.18 .72	4.15 .38	3.55 .76	0.74	.48
Older Per.	3.75 .86	3.89 .71	3.18 .99	3.76 .99	2.94 .82	3.27 .94	0.34	.71

df for all analyses = 2,68

OPTIONS FOR HELP: Tribe X Level of Native American Identification

A 3(tribal membership) by 2(level of identification with Native American beliefs) Multiple Analysis of Variance (MANOVA) was performed with the 7 options for help, averaged across problem situations, as the dependent variables. The multivariate F (.46) for the main effect of level of Native American identification was nonsignificant (.86). Table 22 depicts the mean ratings on the options for help for each level of Native American identification. The multivariate F (.57) for the interaction effect was nonsignificant (p = .89). Table 23 depicts the mean ratings on the options for help for each level of Native American identification within each tribal group.

The multivariate F for the main effect of tribal membership was identical to the Tribe by Gender analysis.

TABLE 24

Options for Help Ratings For Each Gender

Option	Male Mean	SD	Female Mean	SD	F	p
Spiritual	3.16	.98	3.35	.94	1.26	.27
Friend	3.62	.86	3.82	.71	2.32	.13
Doctor	3.34	.74	3.46	.71	0.91	.34
On Own	2.53	.99	2.14	.84	6.44	.01
Family	3.68	.83	3.83	.74	1.20	.28
Mental	3.73	.78	3.97	.66	3.90	.05
Older Per.	3.35	.93	3.40	.89	0.16	.76

df for all analyses = 1,151

OPTIONS FOR HELP: RACE X GENDER

A 2(racial identity) by 2(gender) Multivariate Analysis of Variance (MANOVA) was performed with the 7 options for help, averaged across problem situations, as the dependent variables. The multivariate F (2.09) for the main effects of gender was significant ($p < .05$). For the follow-up ANOVAs, a Bonferroni alpha of .007 was derived by dividing .05 by the number of options (7). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, no significant gender main effects were found for any specific option. Table 24 depicts the mean ratings on the options for help for gender. The multivariate F (1.55) for the interaction effects was nonsignificant ($p = .16$). Table 25 depicts the mean ratings on the options for help for each gender within each racial group. The multivariate F (5.14) for the main

effect of racial identity was significant ($p < .001$). For the follow-up ANOVAs, a Bonferroni alpha of .007 was derived by dividing .05 by the number of options (7). This was done to maintain a family wise alpha level of .05 and to guard against Type I error.

TABLE 25

Options for Help Ratings For Each Gender by Racial Group

Options	Native American Male Mn, SD	Native American Female Mn, SD	Caucasian Male Mn, SD	Caucasian Female Mn, SD	F	p
Spiritual	3.46 .99	3.56 .95	2.87 .96	3.13 .88	0.23	.63
Friend	3.58 .95	3.64 .78	3.66 .81	4.00 .64	1.21	.27
Doctor	3.42 .84	3.46 .70	3.26 .69	3.46 .72	0.42	.52
On Own	2.41 .99	2.30 .98	2.65 .99	1.98 .72	3.32	.07
Family	3.66 .92	3.68 .82	3.70 .80	3.97 .69	0.86	.36
Mental	3.64 .98	3.97 .71	3.82 .45	3.96 .63	0.65	.42
Older Per.	3.71 .91	3.57 .92	2.99 .94	3.23 .88	1.49	.22

df for all analyses = 1,164

TABLE 26

Options for Help Ratings For Each Racial Group

Option	Native American Mean SD	Caucasian Mean SD	F	p
Spiritual	3.51 .98	3.00 .95	9.94	.001
Friend	3.61 .86	3.83 .73	2.83	.04
Doctor	3.44 .78	3.36 .71	0.41	.54
On Own	2.36 .99	2.31 .87	0.17	.76
Family	3.67 .86	3.83 .77	1.43	.23
Mental	3.80 .84	3.89 .57	0.58	.47
Older Per.	3.63 .91	3.11 .92	11.04	.002

df for all analyses = 1,151

Based upon this alpha level, significant racial identity effects were found for spiritual leader and older person. Native American respondents (3.51) were more likely to recommend a spiritual leader than Caucasian respondents (3.00). Native American respondents (3.63) were more likely to recommend an older person than Caucasian respondents (3.11). Table 26 depicts the mean ratings on the options for help for each racial group.

OPTIONS FOR HELP: Race X Level of Spiritual Involvement

A 2(racial identity) by 2(level of involvement in a spiritual tradition) Multiple Analysis of Variance (MANOVA) was performed with the 7 solutions for help, averaged across problem situations, as the dependent variables. The multivariate F (1.77) for the main effect of level of spiritual involvement was nonsignificant (p = .10). Table 27 depicts the mean ratings on the options for help for each level of spiritual involvement.

TABLE 27

Options for Help Ratings For Each Level of Spiritual Involvement

Option	Level 1 Mean	SD	Level 2 Mean	SD	F	p
Spiritual	3.06	.99	3.49	.81	8.41	.01
Friend	3.73	.79	3.79	.74	0.27	.65
Doctor	3.42	.69	3.43	.75	0.01	.91
On Own	2.28	.87	2.23	.92	0.14	.77
Family	3.74	.76	3.82	.85	0.42	.54
Mental	3.95	.67	3.83	.71	1.17	.29
Older Per.	3.24	.88	3.53	.90	3.86	.05

df for all analyses = 1,151

The multivariate F (.97) for the interaction effect was nonsignificant (p = .46). Table 28 depicts the mean ratings on the options for help for each level of spiritual involvement within each racial group. The multivariate F for the main effect of racial identity was identical to the Race by Gender analysis.

TABLE 28

Options for Help Ratings For Each Level of Spiritual Involvement by Racial Group

Options	Native American		Caucasian			
	Level 1 Mn, SD	Level 2 Mn, SD	Level 1 Mn, SD	Level 2 Mn, SD	F	p
Spiritual	3.53 .99	3.67 .98	2.77 .99	3.32 .72	0.59	.44
Friend	3.69 .69	3.55 .95	3.78 .84	4.02 .54	2.33	.13
Doctor	3.52 .67	3.38 .82	3.32 .70	3.48 .73	1.65	.20
On Own	2.30 .88	2.39 .99	2.26 .87	2.08 .84	0.78	.38
Family	3.69 .66	3.66 .99	3.80 .83	3.98 .61	0.65	.42
Mental	3.98 .77	3.73 .88	3.92 .64	3.93 .54	1.24	.27
Older Per.	3.47 .82	3.75 .97	3.02 .944	3.30 .84	0.00	.98

df for all analyses = 1,151

OPTIONS FOR HELP: Race X Level of Spiritual Identification

A 2(racial identity) by 2(level of identification with a spiritual tradition) Multiple Analysis of Variance (MANOVA) was performed with the 7 options for help, averaged across problem situations, as the dependent variables. The multivariate F (.70) for the main effect of level of spiritual identification was nonsignificant (p = .67). Table 29 depicts the mean ratings on the options for help for each level of spiritual identification. The multivariate F (.41) for the interaction effect was nonsignificant (p = .90). Table 30 depicts the mean ratings on the options for help for each level of spiritual identification within

each racial group. The multivariate F for the main effect of racial identity was identical to the Race by Gender analysis.

TABLE 29

Options for Help Ratings For Each Level of Spiritual Identification

Option	Level 1 Mean	SD	Level 2 Mean	SD	F	p
Spiritual	3.09	.99	3.37	.90	2.88	.09
Friend	3.63	.82	3.83	.72	2.13	.15
Doctor	3.38	.79	3.45	.71	0.24	.62
On Own	2.27	.90	2.25	.94	0.02	.89
Family	3.65	.75	3.84	.78	1.84	.18
Mental	3.91	.74	3.88	.68	0.07	.79
Older Per.	3.20	.94	3.46	.88	1.76	.19

df for all analyses = 1,151

TABLE 30

Options for Help Ratings For Each Level of Spiritual Identification by Racial Group

Options	Native American Level 1 Mn, SD	Native American Level 2 Mn, SD	Caucasian Level 1 Mn, SD	Caucasian Level 2 Mn, SD	F	p
Spiritual	3.32 .99	3.59 .94	2.86 .97	3.16 .86	0.00	.95
Friend	3.57 .76	3.63 .87	3.68 .88	4.02 .57	0.03	.31
Doctor	3.50 .75	3.42 .76	3.27 .82	3.47 .65	1.18	.28
On Own	2.36 .99	2.34 .99	2.18 .80	2.16 .89	0.00	.99
Family	3.59 .66	3.70 .91	3.71 .83	3.99 .65	0.37	.54
Mental	3.95 .75	3.81 .86	3.88 .72	3.95 .50	0.67	.41
Older Per.	3.45 .89	3.68 .92	3.03 .99	3.24 .83	0.01	.94

df for all analyses = 1,151

PROBLEM SEVERITY RATINGS: Tribe X Gender

A 3(tribal membership) by 2(gender) Multiple Analysis of Variance (MANOVA) was performed with the 9 ratings of problem

severity as the dependent variables. The multivariate F (2.62) for the main effect of gender was significant ($p < .01$). For the follow-up ANOVAs, a Bonferroni alpha of .005 was derived by dividing .05 by the number of problem situations (9). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, a significant gender main effect was found for the violent drinking situation. On the average male Native American respondents (4.60) rated violent drinking as less severe than did female Native American respondents (4.94). Table 31 depicts the mean ratings for problem severity for each gender. The multivariate F (.86) for the interaction effect was nonsignificant ($p = .63$). Table 32 depicts the mean ratings for problem severity for each gender within each tribal group.

TABLE 31

Problem Severity Ratings For Each Gender

Problem	Male		Female			
	Mean	SD	Mean	SD	F	p
Relation	4.26	.66	4.24	.74	0.01	.94
Child Dis.	4.04	.82	4.38	.58	3.36	.08
Depress.	4.14	.73	4.30	.78	0.62	.43
TV voices	4.72	.72	4.67	.67	0.19	.79
Grieving	3.77	.99	3.83	.98	0.04	.84
Night voice.	2.68	.98	2.68	.99	0.37	.56
Violent	4.60	.79	4.94	.22	8.50	.005
Physical	4.10	.83	3.77	,98	1.93	.18
Rude Beh.	3.63	.84	3.25	.96	2.02	.16

df for all analyses = 1,69

The multivariate F (1.42) for the main effect of tribal membership was nonsignificant (p = .43). Table 33 depicts the mean ratings for problem severity for each tribal group.

TABLE 32

Problem Severity Ratings For Each Gender by Tribal Group

Problem	Tribe 1 Male Mn, SD	Tribe 1 Female Mn, SD	Tribe 2 Male Mn, SD	Tribe 2 Female Mn, SD	Tribe 3 Male Mn, SD	Tribe 3 Female Mn, SD	F	p
Relation	4.27 .79	4.43 .79	4.25 .71	4.20 .79	4.25 .46	4.10 .57	0.28	.76
Child Dis.	4.00 .63	4.54 .58	4.25 .99	4.40 .52	3.88 .99	4.20 .63	0.41	.67
Depress.	4.18 .60	4.00 .82	3.88 .84	4.50 .71	4.38 .74	4.40 .84	1.57	.22
TV voices	4.91 .30	4.82 .61	4.75 .71	4.60 .70	4.50 .99	4.60 .70	0.17	.84
Grieving	3.82 .99	3.79 .99	4.13 .99	3.80 .92	3.38 .99	3.90 .99	0.68	.51
Night voice.	2.55 .93	2.68 .99	2.75 .99	3.20 .99	2.75 .99	2.70 .99	0.20	.82
Violent	4.55 .52	4.93 .26	4.50 .99	5.00 .00	4.75 .46	4.90 .32	0.66	.52
Physical	4.55 .93	4.11 .99	3.75 .89	3.80 .92	4.00 .76	3.40 .97	0.58	.57
Rude Beh.	4.00 .78	3.46 .99	3.63 .92	3.30 .95	3.25 .99	3.00 .94	0.13	.88

df for all analyses = 2,69

TABLE 33

Problem Severity Ratings For Each Tribal Group

Problem	Tribe 1 Mean	SD	Tribe 2 Mean	SD	Tribe 3 Mean	SD	F	p
Relation	4.35	.79	4.23	.76	4.18	.52	0.38	.69
Child Dis	4.27	.61	4.33	.78	4.04	.94	0.79	.46
Depress	4.09	.71	4.19	.78	4.39	.79	0.84	.44
TV voices	4.87	.46	4.68	.71	4.55	.89	1.33	.27
Grieving	3.80	.99	3.96	.96	3.64	.99	0.38	.69
Night voice	2.61	.96	2.98	.99	2.73	.99	0.52	.60
Violent	4.74	.39	4.75	.53	4.83	.39	0.21	.81
Physical	4.33	.96	3.78	.90	3.70	.87	3.00	.06
Rude Beh.	3.73	.96	3.46	.94	3.13	.99	1.96	.15

df for all analyses = 2,69

PROBLEM SEVERITY RATINGS: Tribe X Level of Native American Involvement

A 3(tribal membership) by 2(level of involvement in Native American traditions) Multiple Analysis of Variance (MANOVA) was performed with the 9 ratings of problem severity as the dependent variables. The multivariate F (.85) for the main effect of level of Native American involvement was nonsignificant (.58). Table 34 depicts the mean ratings for problem severity for each level of Native American involvement. The multivariate F (1.19) for the interaction effect was nonsignificant (p = .28). Table 35 depicts the mean ratings for problem severity for each level of Native American involvement within each tribal group. The multivariate F for the main effect tribal membership was identical to the Tribe by Gender analysis.

TABLE 34

Problem Severity Ratings For Each Level of Native American Involvement

Problem	Level 1 Mean	SD	Level 2 Mean	SD	F	p
Relation	4.32	.62	4.20	.74	0.28	.60
Child Dis.	4.26	.66	4.27	.99	0.01	.94
Depress.	4.25	.79	4.18	.76	0.14	.71
TV voices	4.64	.70	4.78	.54	0.61	.44
Grieving	3.89	.99	3.58	.99	1.15	.29
Night voice.	2.80	.99	2.75	.99	0.03	.86
Violent	4.79	.56	4.85	.38	0.27	.61
Physical	3.87	.96	3.98	.86	0.18	.67
Rude Beh.	3.51	.95	3.13	.96	1.86	.18

df for all analyses = 1,69

TABLE 35

Problem Severity Ratings For Each Level of Native American Involvement by Tribal Group

Problem	Tribe 1 Lv. 1 Mn, SD	Tribe 1 Lv. 2 Mn, SD	Tribe 2 Lv. 1 Mn, SD	Tribe 2 Lv. 2 Mn, SD	Tribe 3 Lv. 1 Mn, SD	Tribe 3 Lv. 2 Mn, SD	F	p
Relation	4.40 .71	4.36 .93	4.42 .67	3.83 .75	4.08 .49	4.40 .55	1.58	.21
Child Dis.	4.44 .58	4.28 .73	4.33 .49	4.33 .99	4.00 .91	4.20 .99	0.29	.75
Depress.	4.12 .73	3.93 .83	4.33 .77	4.00 .89	4.30 .86	4.60 .55	0.69	.51
TV voices	4.80 .65	4.93 .27	4.50 .80	5.00 .00	4.62 .65	4.40 .99	1.11	.34
Grieving	3.92 .99	3.57 .99	3.83 .99	4.17 .75	3.92 .99	3.00 .99	1.26	.29
Night voice.	2.64 .99	2.64 .99	3.00 .99	3.00 .99	2.77 .99	2.60 .89	0.03	.97
Violent	4.76 .44	4.93 .27	4.75 .87	4.83 .41	4.85 .38	4.80 .45	0.24	.79
Physical	4.40 .99	3.93 .99	3.67 .89	4.00 .89	3.54 .97	4.00 .71	1.71	.19
Rude Beh.	3.72 .99	3.43 .99	3.58 .79	3.12 .99	3.23 .99	2.80 .99	0.03	.96

df for all analyses = 2,69

PROBLEM SEVERITY RATINGS: Tribe X Level of Native American Identification

A 3(tribal membership) by 2(level of identification with Native American traditions) Multiple Analysis of Variance (MANOVA) was performed with the 9 ratings of problem severity as the dependent variables. The multivariate F (1.11) for the main effect of level of Native American identification was nonsignificant (p = .37). Table 36 depicts the mean ratings for problem severity for each level of Native American identification. The multivariate F (.81) for the interaction effect was nonsignificant (p = .69). Table 37 depicts the mean ratings for problem severity for each level of Native American identification within each tribal group. The multivariate F for the main effect of tribal membership was identical to the the Tribe by Gender analysis.

TABLE 36

Problem Severity Ratings For Each Level of Native American Identification

Problem	Level 1 Mean	SD	Level 2 Mean	SD	F	p
Relation	4.41	.59	4.22	.66	1.06	.31
Child Dis.	4.22	.71	4.27	.80	0.05	.82
Depress.	4.30	.72	4.21	.74	0.20	.65
TV voices	4.79	.36	4.65	.80	0.67	.42
Grieving	4.13	.99	3.58	.99	3.74	.06
Night voice.	3.00	.99	2.73	.99	0.81	.37
Violent	4.92	.23	4.76	.57	1.63	.21
Physical	3.91	.90	3.91	.89	0.00	.98
Rude Beh.	3.41	.92	3.37	.99	0.02	.88

df for all analyses = 1,69

TABLE 37

Problem Severity Ratings For Each Level of Native American Identification by Tribal Group

Problem	Tribe 1 Lv. 1 Mn, SD	Tribe 1 Lv. 2 Mn, SD	Tribe 2 Lv. 1 Mn, SD	Tribe 2 Lv. 2 Mn, SD	Tribe 3 Lv. 1 Mn, SD	Tribe 3 Lv. 2 Mn, SD	F	p
Relation	4.29 .69	4.46 .86	4.80 .45	4.00 .71	4.13 .64	4.20 .42	2.54	.09
Child Dis.	4.47 .62	4.31 .65	4.20 .45	4.39 .87	4.00 .99	4.10 .88	0.33	.72
Depress.	4.18 .64	3.96 .84	4.60 .55	4.08 .86	4.13 .99	4.60 .52	1.91	.16
TV voices	4.88 .33	4.82 .66	5.00 .00	4.54 .78	4.50 .76	4.60 .97	0.74	.48
Grieving	4.18 .99	3.50 .99	4.20 .84	3.85 .98	4.00 .99	3.40 .99	0.12	.89
Night voice.	2.71 .99	2.60 .99	3.80 .99	2.69 .99	2.50 .99	2.90 .99	1.68	.19
Violent	4.88 .33	4.77 .43	5.00 .00	4.69 .86	4.88 .35	4.80 .42	0.26	.77
Physical	4.47 .94	4.05 .99	4.00 .71	3.69 .95	3.25 .99	4.00 .67	2.46	.09
Rude Beh.	3.71 .98	3.55 .99	3.40 .55	3.46 .99	3.43 .99	3.10 .99	0.07	.94

df for all analyses = 2,69

PROBLEM SEVERITY RATINGS: Race X Gender

A 2(racial identity) by 2(gender) Multiple Analysis of Variance (MANOVA) was performed with the 9 ratings of problem severity as the dependent variables. The multivariate F (2.93) for the main effect of gender was significant ($p < .01$). For the follow-up ANOVAs, a Bonferroni alpha of .005 was derived by dividing .05 by the number of problem situations (9). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, a significant gender main effect was found for child discipline. In examining the responses of males and females, averaged across both races, it appears that Females (4.37) rated problem 2 child discipline as more severe than did Males (3.93). Table 38 depicts the mean ratings for problem severity for each gender. The multivariate F (1.40) for the interaction effect was nonsignificant ($p = .19$). Table 39 depicts the mean ratings for problem severity for each gender within each racial group. The multivariate F (5.62) for the main effect of racial identity was significant ($p < .01$). For the follow-up ANOVAs, a Bonferroni alpha of .005 was derived by dividing .05 by the number of problem situations (9). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, significant racial identity effects were found for the problem situations of voices at night, physical complaints, and rude behavior. In examining the responses of Native Americans and Caucasians, it appears that Native American respondents rated voices at night, physical complaint, and rude behavior as more severe than did

Caucasian respondents. Table 40 depicts the mean ratings for problem severity for each racial group.

TABLE 38

Problem Severity Ratings For Each Gender

Problem	Male Mean	SD	Female Mean	SD	F	p
Relation	4.06	.83	4.29	.71	3.25	.07
Child Dis.	3.93	.98	4.37	.66	11.00	.001
Depress.	3.91	.87	4.17	.76	3.52	.07
TV voices	4.73	.64	4.67	.72	0.27	.64
Grieving	3.50	.91	3.68	.96	1.13	.29
Night voice	3.12	.99	2.98	.99	0.41	.54
Violent	4.73	.61	4.93	.36	6.43	.01
Physical	3.76	.96	3.74	.99	0.01	.93
Rude Beh.	3.24	.95	3.06	.88	1.25	.27

df for all analyses = 1,151

TABLE 39

Problem Severity Ratings For Each Gender by Racial Group

Problem	Native American Male Mn,	SD	Native American Female Mn,	SD	Caucasian Male Mn,	SD	Caucasian Female Mn,	SD	F	p
Relation.	4.26	.66	4.31	.75	3.86	.99	4.28	.67	1.93	.17
Child Dis.	4.04	.94	4.44	.58	382	.99	4.31	.73	0.11	.74
Depress.	4.15	.72	4.18	.82	3.68	.99	4.16	.72	2.48	.12
TV voices	4.74	.71	4.73	.64	4.73	.55	4.62	.83	0.14	.71
Grieving	3.78	.99	3.81	.99	3.23	.75	3.55	.88	0.73	.40
Night voice	2.67	.99	2.79	.99	3.55	.99	3.17	.99	1.53	.22
Violent	4.59	.69	4.94	.25	4.86	.47	4.91	.43	3.56	.06
Physical	4.15	.91	3.89	.99	3.36	.99	3.58	.99	1.79	.18
Rude Beh.	3.67	.99	3.33	.99	2.82	.91	2.79	.77	0.92	.34

df for all analyses = 1,151

TABLE 40

Problem Severity Ratings For Each Racial Group

Problem	Native American Mean	SD	Caucasian Mean	SD	F	p
Relation.	4.29	.68	4.07	.81	2.83	.10
Child Dis.	4.24	.76	4.06	.83	1.62	.21
Depress.	4.17	.75	3.92	.84	3.37	.07
TV voices	4.73	.67	4.67	.72	0.25	.63
Grieving	3.80	.99	3.39	.83	5.77	.02
Night voice	2.73	.99	3.36	.99	9.81	.002
Violent	4.77	.52	4.89	.45	2.50	.12
Physical	4.02	.96	3.47	.99	9.57	.002
Rude Beh.	3.50	.99	2.80	.87	19.02	.001

df for all analyses = 1,151

TABLE 41

Problem Severity Ratings For Each Level of Spiritual Involvement

Problem	Level 1 Mean	SD	Level 2 Mean	SD	F	p
Relation	4.15	.77	4.30	.73	1.65	.20
Child Dis.	4.29	.82	4.18	.79	0.73	.40
Depress.	4.12	.77	4.08	.77	0.03	.86
TV voices	4.60	.81	4.78	.62	2.38	.13
Grieving	3.58	.95	3.68	.90	0.42	.52
Night voice	3.02	.99	3.01	.99	0.01	.93
Violent	4.83	.56	4.89	.36	0.67	.42
Physical	3.70	.99	3.81	.99	0.48	.49
Rude Beh.	3.22	.90	3.04	.94	1.52	.22

df for all analyses = 1,151

PROBLEM SEVERITY RATINGS: Race X Level of Spiritual Involvement

A 2(racial identity) by 2(level of involvement in a spiritual tradition) Multiple Analysis of Variance (MANOVA) was performed

with the the 9 ratings of problem severity as the dependent variables.

TABLE 42

Problem Severity Ratings For Each Level of Spiritual Involvement by Racial Group

Problem	Native American		Caucasian			
	Level 1	Level 2	Level 1	Level 2		
	Mn, SD	Mn, SD	Mn, SD	Mn, SD	F	p
Relation.	4.22 .63	4.39 .79	4.08 .91	4.24 .66	0.00	.98
Child Dis.	4.27 .73	4.32 .78	4.32 .90	4.05 .83	1.44	.23
Depress.	4.30 .74	4.05 .80	3.92 .91	4.11 .74	2.95	.09
TV voices	4.62 .72	5.84 .59	4.58 .90	4.71 .64	0.14	.71
Grieving	3.84 .99	3.76 .99	3.32 .90	3.60 .80	1.27	.26
Night voice	2.62 .99	2.87 .99	3.42 .99	3.14 .99	1.98	.16
Violent	4.78 .60	4.87 .34	4.90 .51	4.91 .37	0.46	.50
Physical	3.95 .99	4.03 .92	3.45 .99	3.60 .99	0.04	.86
Rude Beh.	3.65 .98	3.26 .99	3.79 .81	2.81 .80	1.87	.17

df for all analyses = 1,151

The multivariate F (.98) for the main effect of level of spiritual involvement was nonsignificant (p = .46). Table 41 depicts the mean ratings for problem severity for each level of spiritual involvement. The multivariate F (1.33) for the interaction effect was nonsignificant (p = .23). Table 42 depicts the mean ratings for problem severity for each level of spiritual involvement within each racial group. The multivariate F for the main effect of racial identity was identical to the Race by Gender analysis.

PROBLEM SEVERITY RATINGS: Race X Level of Spiritual Identification

A 2(racial identity) by 2(level of identification with a spiritual tradition) Multiple Analysis of Variance (MANOVA) was performed with the 9 ratings of problem severity as the dependent variables.

TABLE 43

Problem Severity Ratings For Each Level of Spiritual Identification

Problem	Level 1 Mean	SD	Level 2 Mean	SD	F	p
Relation	4.16	.64	4.26	.78	0.52	.47
Child Dis.	4.40	.54	4.15	.46	3.06	.08
Depress.	4.16	.81	4.08	.80	0.33	.57
TV voices	4.63	.77	4.72	.66	0.59	.44
Grieving	3.83	.98	3.54	.89	3.10	.08
Night voice	3.01	.99	3.01	.99	0.00	.97
Violent	4.88	.46	4.85	.45	0.16	.69
Physical	3.77	.99	3.75	.98	0.01	.93
Rude Beh.	3.24	.93	3.08	.86	1.03	.31

df for all analyses = 1,151

TABLE 44

Problem Severity Ratings For Each Level of Spiritual Identification by Racial Group

Problem	Native American Level 1 Mn, SD		Native American Level 2 Mn, SD		Caucasian Level 1 Mn, SD		Caucasian Level 2 Mn, SD		F	p
Relation.	4.22	.67	4.33	.73	4.11	.70	4.19	.83	0.02	.90
Child Dis.	4.34	.78	4.27	.74	4.44	.85	4.04	.85	1.40	.24
Depress.	4.35	.71	4.10	.80	3.96	.90	4.06	.80	1.56	.21
TV voices	4.74	.54	4.73	.72	4.52	.99	4.72	.60	0.70	.41
Grieving	4.26	.96	3.60	.99	3.41	.99	3.49	.78	3.36	.07
Night voice	2.70	.99	2.77	.99	3.33	.99	3.25	.99	0.16	.69
Violent	4.87	.34	4.79	.53	4.89	.58	4.90	.35	0.37	.54
Physical	4.13	.99	3.92	.96	3.41	.99	3.59	.99	1.20	.28
Rude Beh.	3.74	.92	3.33	.99	2.74	.94	2.83	.73	2.49	.12

df for all analyses = 1,151

The multivariate F (.99) for the main effect of level of spiritual identification was nonsignificant (p = .45). Table 43 depicts the mean ratings for problem severity for each level of spiritual identification. The multivariate F (1.39) for the interaction effect was nonsignificant (p = .20). Table 44 depicts the mean ratings for problem severity for each level of spiritual identification within each racial group. The multivariate F for the main effect of racial identity was identical to the Race by Gender analysis.

Analysis of Preferred Options For Help For Each Problem Situation

Next in analyzing the data from the Sources of Referral questionnaire, differences among the preferred options for help for each problem situation were examined. These analyses focused on tribal differences and racial differences in order to examine more closely the previous findings concerning these variables.

Tribal Membership: Relationship Difficulty

A one way (tribal membership) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for relationship difficulty, as the dependent variables. The multivariate F (1.89) for the main effect of tribal membership was significant (p < .03). For the follow-up ANOVAs, a Bonferroni alpha of .007 was derived by dividing .05 by the number of options for help (9). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, a significant main effect for the option of spiritual leader was found. Table 45 depicts the mean ratings of the tribal groups for each option for relationship difficulty.

TABLE 45

Options For Help Ratings For Relationship Difficulty For Each Tribal Group

Option	Tribe 1 Mean	SD	Tribe 2 Mean	SD	Tribe 3 Mean	SD	F	p
Spiritual	3.90	1.24	3.65	1.19	2.89	1.26	5.63	.005
Friend	3.72	1.27	4.19	1.25	3.33	1.52	0.67	.53
Doctor	2.57	1.22	2.73	1.37	2.61	1.51	0.18	.90
On own	3.32	1.58	2.67	1.51	3.65	1.27	2.72	.07
Family	3.18	1.43	2.81	1.34	2.88	1.38	0.41	.70
Mental	3.51	1.56	4.66	0.72	3.73	1.43	4.32	.01
Older per.	3.19	1.31	3.40	1.36	2.78	1.21	1.35	.28

df for all analyses = 2,75

Since the follow-up t test comparisons required analyzing a series of three t tests, a Bonferroni alpha was computed to maintain a family-wise alpha level of .05. The new alpha level (.02) was computed by dividing .05 by 3.

Participants from Tribe 1 (3.9) were more likely to recommend a spiritual leader than participants from Tribe 3 (2.8) ($t(57) = 3.2$, $p < .001$). No significant difference was found between Tribe 1 and Tribe 2 (3.6) ($t(60) = 1.5$, $p < .15$) nor between Tribe 2 and Tribe 3 ($t(39) = 1.8$, $p < .09$).

Child Discipline Difficulty

A one way (tribal membership) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for child discipline problem, as the dependent variables. The multivariate F (1.04) for the main effect of tribal membership was nonsignificant (p

= .41). Table 46 depicts the mean ratings of the tribal groups for each option for child discipline difficulty.

TABLE 46

Options For Help Ratings For Child Discipline Difficulty For Each Tribal Group

Option	Tribe 1		Tribe 2		Tribe 3			
	Mean	SD	Mean	SD	Mean	SD	F	p
Spiritual	3.33	1.58	3.05	1.56	2.42	1.22	2.35	.10
Friend	3.30	1.27	3.24	1.04	3.32	1.38	0.02	.98
Doctor	3.43	1.53	4.10	0.94	3.26	1.41	2.23	.11
On own	2.25	1.32	2.57	1.40	2.42	1.26	0.42	.66
Family	4.00	1.09	3.57	1.33	3.95	1.13	0.98	.38
Mental	4.28	1.20	4.62	0.67	4.05	1.18	1.42	.25
Older per.	3.80	1.16	3.43	1.25	3.16	1.39	1.87	.16

df for all analyses = 2,77

TABLE 47

Options For Help Ratings For Depression For Each Tribal Group

Option	Tribe 1		Tribe 2		Tribe 3			
	Mean	SD	Mean	SD	Mean	SD	F	p
Spiritual	3.67	1.48	3.48	1.33	2.89	1.41	1.90	.16
Friend	3.92	1.20	3.86	1.15	3.84	1.12	0.04	.96
Doctor	3.89	1.27	4.10	1.04	3.58	1.22	0.93	.40
On own	2.02	1.06	2.48	1.47	2.16	1.30	0.91	.41
Family	3.85	1.20	3.33	1.28	3.68	0.89	1.34	.27
Mental	4.05	1.26	4.48	0.68	4.42	0.84	1.47	.24
Older per.	3.64	1.29	3.62	1.20	3.48	1.17	0.12	.89

df for all analyses = 2,76

Depression

A one way (tribal membership) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for depression, as the dependent variables. The multivariate F (1.49) for the main effect of tribal membership was nonsignificant (p = .12). Table 47 depicts the mean ratings of the tribal groups for each option for depression.

Voices from TV

A one way (tribal membership) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for voices from TV, as the dependent variables. The multivariate F (1.65) for the main effect of tribal membership was nonsignificant (p = .07). Table 48 depicts the mean ratings of the tribal groups for each option for voices from a TV.

TABLE 48
Options For Help Ratings For Voices From TV For Each Tribal Group

Option	Tribe 1 Mean	SD	Tribe 2 Mean	SD	Tribe 3 Mean	SD	F	p
Spiritual	3.85	1.56	3.95	1.56	2.84	1.64	2.90	.07
Friend	3.40	1.43	3.33	1.43	3.16	1.26	0.19	.82
Doctor	4.20	1.18	4.28	1.10	3.79	1.55	0.92	.40
On own	1.70	1.22	2.38	1.53	1.58	0.90	2.63	.08
Family	3.40	1.45	3.71	1.27	3.53	1.07	0.39	.68
Mental	4.45	1.10	4.81	0.51	4.79	0.53	1.62	.20
Older per.	3.38	1.41	3.28	1.45	2.79	1.36	1.15	.32

df for all analyses = 2,77

Grieving

A one way (tribal membership) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for grieving, as the dependent variables. The multivariate F (1.92) for the main effect of tribal membership was significant ($p < .03$). For the follow-up ANOVAs, a Bonferroni alpha of .005 was derived by dividing .05 by the number of problem situations (9). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, a significant main effect was found for the option of spiritual leader. Table 49 depicts the mean ratings of the tribal groups for each option for grieving. Since the follow-up t test comparisons required analyzing a series of three t tests, a Bonferroni alpha was computed to maintain a family-wise alpha level of .05. The new alpha level (.02) was computed by dividing .05 by 3.

TABLE 49

Options For Help Ratings For Grieving For Each Tribal Group

Option	Tribe 1		Tribe 2		Tribe 3			
	Mean	SD	Mean	SD	Mean	SD	F	p
Spiritual	4.42	1.10	4.40	0.86	3.56	1.28	5.25	.005
Friend	4.28	1.03	3.83	1.15	3.75	1.11	2.22	.11
Doctor	3.03	1.41	3.94	1.04	3.08	1.35	3.68	.03
On own	2.27	1.43	2.48	1.57	2.13	1.21	0.36	.74
Family	4.21	1.11	4.01	1.21	3.92	1.26	0.81	.47
Mental	3.57	1.43	4.55	0.94	3.73	1.48	4.20	.02
Older per.	4.12	1.28	3.94	1.23	3.58	1.22	1.53	.23

df for all analyses = 2,77

On the average, respondents from Tribe 1 (4.4) ($t(58) = 2.6$, $p < .01$) and Tribe 2 (4.4) ($t(39) = 3.1$, $p < .001$) were more likely to recommend spiritual leader for grieving than respondents from Tribe 3 (3.5).

TABLE 50

Options For Help Ratings For Voices at Night For Each Tribal Group

Option	Tribe 1 Mean	SD	Tribe 2 Mean	SD	Tribe 3 Mean	SD	F	p
Spiritual	4.31	1.29	4.42	1.24	4.10	1.32	0.53	.63
Friend	3.44	1.53	3.88	1.37	3.43	1.18	0.67	.56
Doctor	2.58	1.66	3.26	1.42	2.41	1.33	2.03	.15
On own	2.17	1.32	2.59	1.68	2.30	1.32	0.72	.48
Family	3.81	1.40	4.01	1.11	3.34	1.00	1.57	.24
Mental	2.73	1.71	3.90	1.56	2.89	1.42	4.03	.02*
Older per.	4.54	1.03	4.23	1.22	3.82	1.43	2.01	.14

df for all analyses = 2,76

TABLE 51

Options For Help Ratings For Violent Drinking Behavior For Each Tribal Group

Option	Tribe 1 Mean	SD	Tribe 2 Mean	SD	Tribe 3 Mean	SD	F	p
Spiritual	3.68	1.46	4.05	1.07	3.21	1.44	1.89	.16
Friend	3.80	1.42	3.81	1.08	3.47	1.47	0.44	.65
Doctor	3.34	1.44	4.05	1.16	3.73	1.37	1.97	.15
On own	2.19	1.35	2.24	1.51	1.74	1.24	0.88	.42
Family	4.05	1.22	3.67	1.15	3.79	0.92	0.87	.42
Mental	4.24	1.26	4.57	0.87	4.52	0.84	0.82	.45
Older per.	3.98	1.24	3.71	1.23	3.42	1.35	0.29	.28

df for all analyses = 2,78

No significant difference was found between Tribe 1 and Tribe 2 ($t(61) = -.5$, $p < .61$).

Voices at Night

A one way (tribal membership) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for voices at night, as the dependent variables. The multivariate F (1.28) for the main effect of tribal membership was nonsignificant ($p = .23$). Table 50 depicts the mean ratings of the tribal groups for each option for voices at night.

Violent Drinking Behavior

A one way (tribal membership) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for violent drinking behavior, as the dependent variables.

TABLE 52

Options For Help Ratings For Physical Complaints For Each Tribal Group

Option	Tribe 1		Tribe 2		Tribe 3			
	Mean	SD	Mean	SD	Mean	SD	F	p
Spiritual	2.88	1.58	3.18	1.47	2.05	1.31	2.90	.07
Friend	3.10	1.45	3.23	1.38	2.94	1.13	0.22	.81
Doctor	4.93	0.26	4.77	0.69	4.84	0.38	0.92	.40
On own	1.83	1.18	2.18	1.47	1.73	0.93	0.83	.44
Family	3.81	1.42	3.55	1.40	3.37	1.01	0.76	.47
Mental	2.93	1.40	3.50	1.41	2.84	1.64	1.38	.30
Older per.	3.27	1.53	3.27	1.49	2.79	1.13	0.81	.45

df for all analyses = 2,79

The multivariate F (1.19) for the main effect of tribal membership was nonsignificant ($p = .29$). Table 51 depicts the mean

ratings of the tribal groups for each option for violent drinking behavior.

Physical Complaints

A one way (tribal membership) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for physical complaints, as the dependent variables. The multivariate F (.91) for the main effect of tribal membership was nonsignificant (p = .55). Table 52 depicts the mean ratings of the tribal groups for each option for physical complaints.

Rude Behavior

A one way (tribal membership) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for rude behavior, as the dependent variables.

TABLE 53

Options For Help Ratings For Rude Behavior For Each Tribal Group

Option	Tribe 1		Tribe 2		Tribe 3			
	Mean	SD	Mean	SD	Mean	SD	F	p
Spiritual	3.12	1.55	3.43	1.43	2.00	1.12	5.53	.01
Friend	4.35	1.14	4.02	1.32	3.93	1.39	0.66	.53
Doctor	2.10	1.39	2.64	1.40	2.35	1.32	1.02	.36
On own	3.14	1.52	2.87	1.66	2.62	1.00	0.94	.43
Family	3.83	1.36	3.62	1.40	3.57	1.00	0.37	.73
Mental	3.17	1.41	3.90	1.02	2.71	1.54	4.16	.02
Older per.	3.81	1.23	3.90	1.38	3.29	1.31	1.90	.16

df for all analyses = 2,78

The multivariate F (1.48) for the main effect of tribal membership was nonsignificant (p = .13). Table 53 depicts the mean ratings of the tribal groups for each option for rude behavior.

TABLE 54

Options For Help Ratings For Relationship Difficulty For Each Racial Group

Option	Native American		Caucasian			
	Mean	SD	Mean	SD	F	p
Spiritual	3.63	1.27	3.76	1.14	0.54	.49
Friend	3.54	1.32	3.92	1.22	4.01	.05
Doctor	2.68	1.34	2.76	1.28	0.26	.66
On own	3.23	1.52	3.02	1.32	0.82	.38
Family	2.91	1.34	3.50	1.21	6.26	.01
Mental	3.86	1.41	3.92	1.23	0.15	.73
Older per.	3.11	1.33	3.22	1.24	0.60	.46

df for all analyses = 1,157

Racial Identity: Relationship Difficulty

A one way (racial identity) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for relationship difficulty, as the dependent variables. The multivariate F (1.69) for the main effect of racial identity was nonsignificant (p = .12). Table 54 depicts the mean ratings for each racial group for each option for relationship difficulty.

Child Discipline Difficulty

A one way (racial identity) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for child discipline difficulty, as the dependent variables. The multivariate F (1.19) for the main effect of racial identity was nonsignificant (p =

.31). 55 depicts the mean ratings for each racial group for each option for child discipline difficulty.

TABLE 55

Options For Help Ratings For Child Discipline Difficulty For Each Racial Group

Option	Native American Mean	SD	Caucasian Mean	SD	F	p
Spiritual	3.04	1.52	2.64	1.24	3.28	.07
Friend	3.29	1.22	3.43	1.14	0.60	.44
Doctor	3.56	1.40	3.64	1.25	0.15	.70
On own	2.38	1.32	2.36	1.32	0.01	.94
Family	3.88	1.16	3.95	1.02	0.19	.66
Mental	4.31	1.09	4.40	0.93	0.27	.61
Older per.	3.56	1.25	3.25	1.26	2.34	.13

df for all analyses = 1,157

Depression

A one way (racial identity) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for depression, as the dependent variables. The multivariate F (4.00) for the main effect of racial identity was significant ($p < .01$). For the follow-up ANOVAs, a Bonferroni alpha of .005 was derived by dividing .05 by the number of problem situations (9). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, a significant main effect was found for the option of a family member. The Caucasian participants (4.2) were more likely to recommend a family member for depression than Native American participants (3.7). Table 56

depicts the mean ratings of the racial groups for each option for depression.

TABLE 56

Options For Help Ratings For Depression For Each Racial Group

Option	Native American Mean	SD	Caucasian Mean	SD	df, F, & p value	
Spiritual	3.42	1.14	3.37	1.38	0.63	.43
Friend	3.82	1.24	4.34	0.92	6.27	.02
Doctor	3.90	1.21	3.69	1.25	2.32	.13
On own	2.21	1.23	2.06	1.23	1.16	.31
Family	3.76	1.23	4.21	0.90	8.62	.004
Mental	4.34	1.07	4.37	1.03	0.37	.57
Older per.	3.68	1.21	3.22	1.25	4.11	.04

df for all analyses = 1,158

TABLE 57

Mean Ratings on the Options For Help Ratings For Voices From TV For Each Racial Group

Option	Native American Mean	SD	Caucasian Mean	SD	F	p
Spiritual	3.63	1.68	3.24	1.54	1.73	.20
Friend	3.36	1.44	3.42	1.32	0.26	.65
Doctor	4.13	1.32	4.07	1.37	0.12	.80
On own	1.91	1.34	1.63	1.11	2.16	.15
Family	3.57	1.37	3.75	1.28	1.22	.28
Mental	4.64	0.90	4.90	0.50	5.09	.03
Older per.	3.21	1.41	2.92	1.24	3.02	.08

df for all analyses = 1,159

Voices from TV

A one way (racial identity) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for voices from TV, as the dependent variables. The multivariate F (2.19) for the main effect of racial identity was significant ($p < .04$). For the follow-up ANOVAs, a Bonferroni alpha of .005 was derived by dividing .05 by the number of problem situations (9). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, no significant main effects were found for any specific option. Table 57 depicts the mean ratings of the racial groups for each option for voices from TV.

Grieving

A one way (racial identity) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for grieving, as the dependent variables. The multivariate F (3.09) for the main effect of racial identity was significant ($p < .01$). For the follow-up ANOVAs, a Bonferroni alpha of .005 was derived by dividing .05 by the number of problem situations (9). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, significant main effects were found for the options of close friend and family member. Caucasian participants (4.4) were more likely to recommend a close friend for grieving than Native American participants (4.0). Caucasian participants (4.5) were also more likely to recommend a family member for grieving than Native American participants (4.1). Table

58 depicts the mean ratings of the racial groups for each option for grieving.

TABLE 58

Options For Help Ratings For Grieving For Each Racial Group

Option	Native American Mean	SD	Caucasian Mean	SD	F	p
Spiritual	4.24	1.13	4.02	1.21	0.52	.46
Friend	4.07	1.11	4.43	0.83	9.14	.003
Doctor	3.23	1.36	2.90	1.36	2.92	.09
On own	2.26	1.43	2.22	1.31	.01	.97
Family	4.19	1.12	4.54	0.76	8.53	.004
Mental	3.83	1.37	3.67	1.32	1.21	.28
Older per.	3.91	1.29	3.64	1.21	1.84	.18

df for all analyses = 1,159

Voices at Night

A one way (racial identity) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for voices at night, as the dependent variables. The multivariate F (13.58) for the main effect of racial identity was significant ($p < .01$). For the follow-up ANOVAs, a Bonferroni alpha of .005 was derived by dividing .05 by the number of problem situations (9). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, significant main effects were found for the options of spiritual leader, mental health professional and older person. Native American (4.3) respondents were more likely to recommend a spiritual leader for voices at night than Caucasian respondents (3.0). Caucasian respondents (4.0) were more likely to recommend a mental health professional for voices at night than

Native American respondents (3.0). Native American respondents (4.2) were more likely to recommend an older person for voices at night than Caucasian respondents (2.9). Table 59 depicts the mean ratings of the racial groups for each option for voices at night.

TABLE 59

Options For Help Ratings For Voices At Night For Each Racial Group

Option	Native American		Caucasian			
	Mean	SD	Mean	SD	F	p
Spiritual	4.32	1.21	3.08	1.54	36.00	.001
Friend	3.56	1.43	3.76	1.27	1.25	.28
Doctor	2.64	1.56	3.01	1.44	2.14	.15
On own	2.22	1.42	2.38	1.38	0.01	.93
Family	3.78	1.37	3.70	1.13	0.17	.82
Mental	3.02	1.63	4.03	1.22	18.00	.001
Older per.	4.24	1.21	2.91	1.37	45.00	.001

df for all analyses = 1,159

Violent Drinking

A one way (racial identity) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for violent drinking behavior, as the dependent variables. The multivariate F (5.08) for the main effect of racial identity was significant ($p < .01$). For the follow-up ANOVAs, a Bonferroni alpha of .005 was derived by dividing .05 by the number of problem situations (9). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, no significant main effects were found any specific option. Table 60 depicts the mean

ratings of the racial groups for each option for violent drinking behavior.

TABLE 60

Options For Help Ratings For Violent Drinking Behavior For Each Racial Group

Option	Native American		Caucasian			
	Mean	SD	Mean	SD	F	p
Spiritual	3.72	1.42	3.40	1.38	1.42	.23
Friend	3.44	1.43	4.12	1.06	3.87	.05
Doctor	3.67	1.41	3.92	1.20	2.33	.13
On own	2.13	1.40	1.66	0.97	7.76	.01
Family	3.90	1.16	4.18	0.99	2.01	.16
Mental	4.41	1.12	4.73	0.58	5.14	.03
Older per.	3.85	1.37	3.31	1.24	5.73	.02

df for all analyses = 1,160

Physical Complaints

A one way (racial identity) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for physical complaints, as the dependent variables. The multivariate F (5.27) for the main effect of racial identity was significant ($p < .01$). For the follow-up ANOVAs, a Bonferroni alpha of .005 was derived by dividing .05 by the number of problem situations (9). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, a significant main effect was found for the option of spiritual leader. Native American participants (2.8) were more open to recommending a spiritual leader for physical complaints than were the Caucasian participants

(1.8). Table 61 depicts the mean ratings of the racial groups for each option for physical complaints.

TABLE 61

Options For Help Ratings For Physical Complaints For Each Racial Group

Option	Native American Mean	SD	Caucasian Mean	SD	F	p
Spiritual	2.82	1.52	1.87	1.03	22.00	.001
Friend	3.15	1.33	3.42	1.11	3.03	.09
Doctor	4.92	0.42	4.93	0.34	1.12	.29
On own	1.90	1.21	1.76	1.19	1.78	.19
Family	3.65	1.38	3.77	1.24	0.21	.68
Mental	3.14	1.54	2.85	1.41	1.24	.28
Older per.	3.29	1.40	2.79	1.36	3.93	.05

df for all analyses = 1,161

Rude Behavior

A one way (racial identity) multiple analysis of variance (MANOVA) was performed with the 7 options for help, for rude behavior, as the dependent variables. The multivariate F (2.72) for the main effect of racial identity was significant (p = .01). For the follow-up ANOVAs, a Bonferroni alpha of .005 was derived by dividing .05 by the number of problem situations (9). This was done to maintain a family wise alpha level of .05 and to guard against Type I error. Based upon this alpha level, a significant main effect was found for the option of spiritual leader. Native American participants (2.9) were more open to a spiritual leader for rude behavior than the Caucasian participants (2.3). Table 62 depicts the mean ratings of the racial groups for each option for rude behavior.

TABLE 62

Options For Help Ratings For Rude Behavior For Each Racial Group

Option	Native American Mean	SD	Caucasian Mean	SD	F	p
Spiritual	2.92	1.52	2.32	1.32	7.32	.005
Friend	4.15	1.25	4.39	0.92	3.37	.07
Doctor	2.32	1.38	2.03	1.10	3.63	.06
On Own	2.90	1.43	2.81	1.43	0.19	.74
Family	3.74	1.39	3.79	1.28	0.01	.95
Mental	3.28	1.41	2.73	1.42	5.74	.02
Older per.	3.72	1.36	3.42	1.31	2.42	.12

df for all analyses = 1,160

Multiple Regression Analysis of MHVQ scales, Options for Help, and Problem Severity

A series of Multiple Regression analyses were computed to determine the relative contribution to MHVQ scores, help options, and ratings of problem severity, respectively of selected predictor variables. Two main sets of multiple regressions were conducted. The predictor variables for the first set were tribal membership, gender, degree of involvement in traditional Native American activities, degree of identification with Native American beliefs, degree of involvement in traditional Christian activities, and degree of identification with Christian beliefs. The predictor variables for the second set utilized racial identity, gender, degree of involvement in a traditional Native American activities, degree of identification with Native American beliefs, degree of involvement in traditional Christian activities, and degree of identification with Christian beliefs

as predictor variables. The Backward method of regression analysis was utilized. In this method, the regression analysis begins with a group of preselected variables (i.e.the variables named above). With each successive step in the analysis, the variable with the least level of significance is removed from the equation. This continues until the equation reaches the level of highest possible statistical probability.

An important consideration in the use of multiple regressions is sample size, which, given the number of variables used in the equations, should at least be 30 (Mosteller & Tuke, 1977) in order to ensure homogeneity of variance and to guard against spurious results. Since two of the tribal samples had an n of less than 30, this did pose a potential problem, which was dealt with by utilizing a "jackknifing procedure" (Mosteller & Tuke, 1977). This involved running the equations several times, each time removing a different subject's data from the data pool. If the Multiple R and the Standard Error change dramatically with the removal of a particular subject's data, then that set of data is considered spurious and is removed from the final analysis. The variations in the Multiple R and the Standard Error that resulted from the jackknifing procedure were within a range of 0 to .09. This indicated that the samples were fairly homogeneous and that no subject's data needed to be removed.

Since several regressions were computed on the same data, a Bonferonni's alpha was calculated to guard against Type I error. The more conservative Bonferonni alpha is also helpful in guarding against overgeneralization of results, which is a possibility given the

previously mentioned small sample size. For the regressions involving the MHVQ scales a Bonferroni alpha of .006 was derived by dividing .05 by the number of scales (8). For the regressions involving the options for help, averaged across problem situations, a Bonferroni alpha of .007 was derived by dividing .05 by the number of options (7). For the regressions involving the ratings of severity for each problem situation, a Bonferroni alpha of .006 was derived by dividing .05 by the number of problem situations (9). Those equations which matched or exceeded the appropriate alpha levels were considered to be significant.

MHVQ: Multiple Regressions with Tribal Membership

Within the first set of multiple regressions, which utilized tribal membership, gender, and the traditionality variables, the equation for scale 1 (Self Acceptance), from the MHVQ, was nonsignificant (Multiple R = .30, (6,82), $p < .24$). The equation for scale 2 (Negative Traits) was nonsignificant (Multiple R = .39, (6,82), $p < .03$). The equation for scale 3 (Achievement) was nonsignificant (Multiple R = .32, (6,81), $p < .16$). The equation for scale 4 (Affective Control) was nonsignificant (Multiple R = .37, (6,81), $p < .054$). The equation for scale 5 (Good Interpersonal Relations) was nonsignificant (Multiple R = .34, (6,82), $p < .09$). The equation for scale 6 (Untrustworthiness) was nonsignificant (Multiple R = ..35, (6,81), $p < .09$). The equation for scale 8 (Receptivity to Unconventional Experiences) was nonsignificant (Multiple R = .24, (6,81), $p < .56$).

The equation for scale 7 (Religious Commitment) was significant (Multiple R = .49, (6,81), $p < .0009$) with Tribal

membership (beta = -.318, p < .004) and degree of participation in traditional Native American activities (beta = .311, p < .04) as the significant predictors in the equation. The degree of involvement in traditional Native American activities was positively correlated with the perception of religious commitment as mentally healthy. It also appears that respondents from Tribe 3 were less likely than respondents from Tribe 1 and Tribe 2 to perceive religious commitment as mentally healthy, which is consistent with the previous ANOVA finding.

OPTIONS FOR HELP: Multiple Regressions with Tribal Membership

For the Options for help, averaged across problem situations, the equation for option 1 (Spiritual Leader) was nonsignificant (Multiple R = .32, (6,71), p < .23). The equation for option 2 (Close Friend) was nonsignificant (Multiple R = .18, (6,70), p < .89). The equation for option 3 (Medical Doctor) was nonsignificant (Multiple R = .23, (6,70), p < .67). The equation for option 4 (On One's Own) was nonsignificant (Multiple R = .17, (6,71), p < .91). The equation for option 5 (Family Member) was nonsignificant (Multiple R = .29, (6,70), p < .39). The equation for option 6 (Mental Health Professional) was nonsignificant (Multiple R = .31, (6,72), p < .29). The equation for option 7 (Older Person) was nonsignificant (Multiple R = .38, (6,67), p < .09).

PROBLEM SEVERITY: Multiple Regressions with Tribal Membership

For ratings of problem severity, the equation for problem #1 (Relationship Difficulty) was nonsignificant (Multiple R = .24, (6,74), p < .60). The equation for problem #2 (Child Discipline Problem) was

nonsignificant (Multiple R = .41, (6,75), p < .03). The equation for problem #3 (Depression) was nonsignificant (Multiple R = .25, (6,74), p < .58). The equation for problem #4 (Voices from TV) was nonsignificant (Multiple R = .23, (6,73), p < .65). The equation for problem #5 (Grieving) was nonsignificant (Multiple R = .26, (6,72), p < .54). The equation for problem #6 (Voices at Night) was nonsignificant (Multiple R = .32, (6,72), p < .26). The equation for problem #7 (Violent Drinking Behavior) was nonsignificant (Multiple R = .39, (6,71), p < .054). The equation for problem #8 (Physical complaints) was nonsignificant (Multiple R = .36, (6,71), p < .12). The equation for problem #9 (Rude Behavior) was nonsignificant (Multiple R = .45, (6,71), p < .013).

MHVQ: Multiple Regressions with Racial Identity

Within the second group of multiple regressions, which utilized, as predictors, racial identity, gender, and the traditionality variables, the equation for scale 1 (Self Acceptance), from the MHVQ, was nonsignificant (Multiple R = .26, (6,163), p < .08). The equation for scale 3 (Achievement) was nonsignificant (Multiple R = .17, (6,162), p < .58). The equation for scale 5 (Good Interpersonal Relations) was nonsignificant (Multiple R = .22, (6,163), p < .19). The equation for scale 6 (Untrustworthiness) was nonsignificant (Multiple R = .20, (6,162), p < .38). The equation for scale 7 (Religious Commitment) was nonsignificant (Multiple R = .23, (6,162), p < .19).

The equation for scale 2 (Negative Traits) was significant (Multiple R = .37, (6,163), p < .0004), with racial identity (beta = .35, p < .0078) and degree of identification with Christian beliefs (beta = -

.23, $p < .05$) as the significant predictors. The Caucasian respondents were less likely than the Native American respondents to perceive negative traits as mentally unhealthy, which was consistent with the previous ANOVA findings. Furthermore, this equation indicates that identification with Christian beliefs was positively associated with the perception of negative traits as mentally unhealthy.

The equation for scale 4 (Affective Control) was significant (Multiple R = .37, (6,162), $p < .0006$) with degree of involvement in Christian activities (beta = .30, $p < .014$) and degree of identification with Christian beliefs (beta = -.24, $p < 05$) as the significant predictors. Degree of involvement in Christian church related activities appears to have been positively associated with the perception of affective control as mentally healthy. Degree of identification with Christian beliefs, however, appears to have been negatively associated with the perception of affective control as mentally healthy.

The equation for scale 8 (Receptivity to Unconventional Experiences) was significant (Multiple R = .29, (4,164), $p < .006$), with degree of identification with traditional Native American beliefs (beta = .25, $p < .0015$) as the significant predictor. This indicates that identification with traditional Native American beliefs was positively associated with the perception of "unconventional spiritual experiences" as mentally healthy.

OPTIONS FOR HELP: Multiple Regressions with Racial Identity

For the Options for help, averaged across problem situations, the equation for option 2 (Close Friend) was nonsignificant (Multiple

R = .25, (6,151), p < .13). The equation for option 3 (Medical Doctor) was nonsignificant (Multiple R = .19, (6,151), p < .46). The equation for option 4 (On One's Own) was nonsignificant (Multiple R = .24, (6,152), p < .19). The equation for option 5 (Family Member) was nonsignificant (Multiple R = .22, (6,151), p < .25). The equation for option 6 (Mental Health Professional) was nonsignificant (Multiple R = .25, (6,153), p < .13). The equation for option 7 (Older Person) was nonsignificant (Multiple R = .31, (6,148), p < .019).

The equation for option 1 (Spiritual Leader) was significant (Multiple R = .39, (6,152), p < .0003) with degree of involvement in Christian church related activities (beta = .38, p < .0025) as the significant predictor. This indicates that involvement in Christian church related activities was positively associated with the likelihood of recommending a spiritual leader as an option for help for various problem situations.

PROBLEM SEVERITY: Multiple Regression with Racial Identity

For ratings of problem severity, the equation for problem #1 (Relationship Difficulty) was nonsignificant (Multiple R = .24, (6,155), p < .14). The equation for problem #3 (Depression) was nonsignificant (Multiple R = .20, (6,154), p < .37). The equation for problem #4 (Voices from TV) was nonsignificant (Multiple R = .14, (6,153), p < .80). The equation for problem #5 (Grieving) was nonsignificant (Multiple R = .28, (6,152), p < .04). The equation for problem #6 (Voices at Night) was nonsignificant (Multiple R = .24, (6,152), p < .19). The equation for problem #7 (Violent Drinking Behavior) was nonsignificant (Multiple R = .24, (6,151), p < .16). The

equation for problem #8 (Physical Complaints) was nonsignificant (Multiple R = .26, (6,151), p < .10).

The equation for problem #2 (Child Discipline) was significant (Multiple R = .33, (6,155), p < .0051), with gender (beta = .26, p < .0011) as the significant predictor. This indicated that female subjects tended to perceive a problem with child discipline as more severe than did the male subjects, which was consistent with the previous ANOVA findings.

The equation for problem #9 (Rude Behavior) was significant (Multiple R = .42, (6,151), p < .0001), with Race (beta = -.41, p < .0026) and degree of participation in traditional Native American activities (beta = -.40, p < .008) as the significant predictors. This indicates that the Native American respondents perceived the rude behavior situation as more problematic than did the Caucasian respondents, which was consistent with the previous ANOVA findings.

CHAPTER IV

DISCUSSION

The purpose of this study was to improve understanding of how Native Americans conceptualize the nature of good mental health by examining their perceptions of various behaviors and attitudes, their perceptions of different problem situations, and their preferences for obtaining help. The study compared the Native American responses with a Caucasian sample in order to highlight culturally unique aspects of the Native American perceptions and also examined potential sources of variance within the Native American sample. It is hoped that such information could serve as a guide for the development of culturally appropriate mental health interventions. The reader should keep in mind that this study focused on college students from Northern Plains and High Plateau tribes and that the generalizability of the results may be limited. Furthermore, the demographic differences between the Caucasian sample and the Native American sample may also limit the interpretation of the results. These issues will be further discussed later in this section.

Native American Mental Health Values

The results provided some support for observations from the literature that, for Native Americans, maintaining healthy interrelationships is important for mental health. On the MHVQ, the

Native American college student responses on Good Interpersonal Relations were not significantly different from the Caucasian responses. However, the Native American respondents were less accepting of Negative Traits than were the Caucasian respondents. Since most of the traits depicted in this scale would negatively impact relationships, this finding may reflect a greater emphasis of the Native American respondents upon protecting the well being of relationships.

This interpretation is further supported by the finding on the Sources of Referral Questionnaire that Native American college students perceived the situation involving rude behavior as more severe than did the Caucasian sample. Furthermore, it was also found that the Native American college sample was more likely than the Caucasian sample to recommend a mental health professional for this situation. Since this situation involved behavior that was potentially disruptive to a network of relationships, this finding further indicates the importance attached to the maintainence of interrelationships.

On the MHVQ, the Native American sample's mean score for Good Interpersonal Relations indicated that this particular scale was perceived by the sample of college students to be associated with good mental health. The items in this scale emphasize the idea that harmonious and supportive interrelationships give purpose and meaning to life. This is consistent with the observations of Brant (1990) and Sue & Sue (1990) that maintaining harmonious bonds with

extended family and tribal members is important since these relationships form the basis of identity.

The Native American sample's mean score on self-acceptance indicated that this scale was also perceived to be associated with good mental health. The items in this scale emphasize the qualities of motivation, responsibility, and respectfulness, which are essential to the development of healthy interrelationships. Therefore, it appears that the Native American college student sample value behaviors and qualities that encourage healthy relationships.

The results also provided some support for the observations in the literature review that spiritual experiences are important in the lives of many Native Americans (Bearcomesout, 1993; Sue & Sue, 1990). Even though a significant difference between Native Americans and Caucasians was not found on the Religious Commitment scale on the MHVQ, the results did show that the members of the Native American college student sample were more accepting, than the Caucasian sample, of Unconventional Experiences, which suggests a greater openness on the part of the Native Americans to supernatural spiritual experiences.

The openness among Native Americans to supernatural experiences was further demonstrated by results from the Sources of Referral Questionnaire. The results involved the two different situations involving voices (TV voices and night voices) which were included to see if the Native American college student sample would make a distinction between "healthy voices" and "unhealthy voices". The two situations differed in terms of source and nature of the

voices. Both the Native American sample and the Caucasian sample perceived the TV voices situation, which involved harsh, critical voices, as suggestive of a severe disorder. However, the Native American sample perceived the night voices situation as much less problematic than did the Caucasian sample. Furthermore the finding that Native American college student respondents were more likely, than Caucasian respondents, to recommend a spiritual leader and an older person for this situation suggests that the Native American sample viewed this as more of a spiritual issue than a "problem". In general, these findings indicate that the Native American college student sample were more accepting of supernatural experiences and that they made a distinction between "healthy" voices and "unhealthy" voices.

Tribal Membership

In general, the results demonstrated that even though the respondents from the three tribes expressed similar values and similar preference for particular sources of help, variations in the degree of belief and preference existed between the tribal groups. Furthermore, the greatest number differences were found between Tribe 1 & Tribe 3, and between Tribe 2 & Tribe 3. The fewest number of differences were found between Tribe 1 and Tribe 2. Since both Tribe 1 and Tribe 2 differed from Tribe 3 in terms of historical lifestyle, but were similar to each other in this regard, the results may indicate that historical lifestyle is an important factor associated with tribal differences. Another difference between the respondents from Tribe 3 and the respondents from Tribe 1 and

Tribe 2 is the degree of belief and involvement in Christian beliefs and practices, which indicates that this factor may also be associated with tribal differences. The specific factors that mediate tribal differences need to be further clarified in future studies. Other factors could include recent history, traditional practices and beliefs, geographic location, current degree of cohesiveness within the tribe, current economic status of tribe, and differences in traditional language (Sue & Sue, 1990).

Traditionality

The lack of significant findings with the traditionality variables may indicate that traditionality is a complex variable that can not be adequately measured by one or two questions. Further research is needed to clarify the various measurable components of traditionality, perhaps through examining specific behaviors and specific beliefs. Aspects of traditionality that could be more closely examined for their influence on current daily life include speaking the tribal language, knowledge of traditional tribal history, knowledge of particular rituals, living on the reservation or within tribal group, following traditional tribal taboos and guidelines, degree of socialization with Native Americans, and involvement in specific rituals (Sue & Sue, 1990).

Gender

Even though the findings involving gender were limited, the study did demonstrated that demographic variables, such as gender, could be a source of variance within the Native American population. Future research should examine other demographic variables within

the Native American community including age, level of education, degree of urbanization of surroundings, and economic status (Trimble, & Lee; 1981).

Limitations of the Study

A major limitation of the study lies in the demographic differences between the Caucasian sample and the Native American sample. These demographic differences, which included age, subject's education level, and education level of the subject's parents, have been shown within the psychological literature to be important sources of variance. Therefore, the previously mentioned interpretations are somewhat tenuous since it is possible that the demographic differences may have contributed to the racial differences in this study. Another limiting factor was that the method for obtaining subjects varied among the different locations. For the Caucasian sample and one of the tribal samples, the subjects were obtained through the classroom. For the other two tribal samples, subjects were approached individually and were requested to participate. The difference in sampling procedure may have induced unknown bias that could have influenced the outcome.

Another important consideration is that the generalizability of the results to all Native Americans is limited since the study is based on three rural tribes. Results from a few tribes can not automatically be applied to all tribes (Trimble, Manson, Dinges, & Medicine, 1984). Another factor that limits generalizability is that a subset of each tribe, i.e. college students, was sampled for this study. Even though the samples were obtained from reservation colleges in order to

increase the similarity between the sample and the reservation population, it can not be assumed that the results apply to the majority of the reservation residents, especially those who have not attended college. The third and most serious limiting factor is the small sample size from two of the reservations (20 and 25), combined with the nonrandom method of sample selection. This increases the possibility that the Native American samples were not representative of the reservation populations, which .further restricts the generalizability of the results of the study.

Future researchers should also keep in mind that gaining approval for research and networking with different tribal groups takes time and effort and that individuals on the reservation are reluctant to discuss their lives with outsiders. These factors can make research challenging particularly in terms of obtaining large samples that are representative of the reservation population.

Treatment Recommendations

Since the results indicate that, for Native Americans, maintaining healthy interrelationships is important for good mental health, it is tentatively recommended that an important focus of therapy for this population should be upon helping the Native American individual enhance healthy relationships with the family and the community. As discussed previously, The Native American mean score on the Self-Acceptance scale suggests that the Native American college students perceive responsible and respectable behaviors to be associated with good mental health. Therefore, encouraging such behaviors could be an acceptable method for

enhancing healthy relationships. Future research needs to further verify the importance of relationships in therapeutic progress as well as clarify the specific behaviors that would be considered responsible and respectful.

The mean scores for Native Americans on the options for help ratings indicate the informal resources that might be utilized to provide support and encouragement to the Native American individual. Such resources, as suggested by the mean scores, could include close friends, family members, spiritual leaders, and older people. The study did find that Native American college student respondents were more likely than Caucasian respondents to recommend a spiritual leader and an older person as viable options for help. This suggests that these two resources may be particularly relevant to the Native American culture and therefore could be beneficial as an access to people in need and as guides in the development of community mental health programs.

The findings involving the receptivity towards supernatural experiences and the different types of voices indicate that personal experiences that might considered unusual by the dominant culture should not automatically be labeled as unhealthy. Instead these experiences should be evaluated in the context of the community's values. Since the Native American college student respondents indicated that a spiritual leader is an acceptable source of guidance, it may also be necessary to explore an individual's perception of a problem in order to determine if involvement with a spiritual leader might be helpful for the individual.

The results of the study demonstrated that variations in mental health values and in preferred sources of help do exist among Native Americans. Such potential variations need to be considered when utilizing mental health strategies with a Native American individual. One potential source of variance, as indicated by the results, is tribal membership as well as the historical lifestyle of the tribe. Another potential source of variance is the degree to which an individual is involved in and believes in Native American traditions. This may be particularly relevant in the preference for informal sources of help and in the role of spirituality in therapy.

Recommendations for Future Research

Since the results demonstrated that Native Americans are a diverse group, future research should focus on the complexity within the Native American population by further exploring the various factors associated with tribal membership, such as historical lifestyle and geographical location, in order to pinpoint the factors that are most associated with tribal differences. Future studies should also engage in a more indepth examination of the different aspects of traditionality in order to better assess this complex variable. Studies should also examine any potential variance in mental health values that may be associated with different demographic variables. Finally, future studies should strive for larger and more representative samples that are randomly selected in order to increase the generalizability of research results.

APPENDIX A
BACKGROUND QUESTIONNAIRE

Primary Tribal Affiliation:

Age:

1) Gender: (0) Male or (1) Female

2) How many years of education have you received?
(0) 0-3; (1) 4-6; (2) 7-9; (3) 10-12; (4) 1-2 college;
(5) 3-5 college; (6) graduate education

3) How large is the city (town) in which you lived longest during your childhood?
(pick one):
(0) less than 1000 (1) 1000 (2) 10,000 (3)100,000
(4) 500,000 (5) 1 million

4) What percent of your life from age 0-10 yrs did you spend on the reservation?
(0) Less then 25% (1) 25% (2) 50% (3) 75%
(4) 100%

5) What percent of your life from age 11-20 did you spend on the reservation?
(0) Less then 25% (1) 25% (2) 50% (3) 75%
(4) 100%

6) What percent of your life from age 21-present did you spend on the reservation?

(0) Less than 25% (1) 25% (2) 50% (3) 75%
(4) 100%

7) How many years of education did your mother receive?

(0) 0-3; (1) 4-6; (2) 7-9; (3) 10-12; (4) 1-2 college;
(5) 3-5 college; (6) graduate education

8) How many years of education did your father receive?

(0) 0-3; (1) 4-6; (2) 7-9; (3) 10-12; (4) 1-2 college;
(5) 3-5 college; (6) graduate education

9) Have you ever seen a mental health professional (psychiatrist, psychologist, counselor, alcohol & drug counselor)? (0) Yes (1) No

10) Has any of your family members ever seen a mental health professional (psychiatrist, psychologist, counselor, alcohol & drug counselor)? (0) Yes (1) No

11) How often do you attend traditional Native American activities, such as pow wows, sweats, drummings, and so on?

not at all	1 -3 times a year	4-6 times a year	7-10 times a year	1 to 3 times a month	once a week	more than once a week
(0)	(1)	(2)	(3)	(4)	(5)	(6)

12) To what degree do you identify with and follow traditional Native American beliefs and practices?

(0)	(1)	(2)	(3)	(4)	(5)	(6)
not at all						completely, part of daily life

13) To what degree do you identify with and follow Christian beliefs and practices?

(0)	(1)	(2)	(3)	(4)	(5)	(6)
not at all						completely, part of daily life

14) How often do you attend Christian church related activities, such as church socials, Sunday services, prayer meetings, etc.

not at all	1 -3 times a year	4-6 times a year	7-10 times a year	1 to 3 times a month	once a week	more than once a week
(0)	(1)	(2)	(3)	(4)	(5)	(6)

15) If you answered "not at all" to all of the above questions, do you follow another form of spirituality? (0) Yes (1) No

16) If so to what degree do you identify with and follow the beliefs and practices within this form of spirituality?

(0)	(1)	(2)	(3)	(4)	(5)	(6)
not at all						completely, part of daily life

17) How often do you attend activities related with this form of spirituality?

not at all	1 -3 times a year	4-6 times a year	7-10 times a year	1 to 3 times a month	once a week	more than once a week
(0)	(1)	(2)	(3)	(4)	(5)	(6)

APPENDIX B

Mental Health Values Questionnaire (MHVQ)

This test measures what people think is important for good mental health. Different people have different ideas about what it means to be mentally and emotionally healthy.

The following statements tell something about a person. Read each statement carefully. Then decide, based on <u>your opinion</u>, whether the statement means that the person has good mental health or poor mental health.

For each statement, put a 1 next to it if the statement indicates very poor mental health. Put a 5 next to it if the statement indicates very good mental health. If you think the statement falls somewhere in between, mark either 2, 3, or 4 according to the following guide:

1 = Very poor mental health

2 = Poor mental health

3 = Neutral, statement is not related to mental health

4 = Good mental health

5 = Very good mental health

Enter only <u>one</u> number for each question. Try to answer every question. Answer according to what <u>you</u> think.

1 = Very poor mental health
2 = Poor mental health
3 = Neutral, statement is not related to mental health
4 = Good mental health
5 = Very good mental health

_____ 1. The person never becomes violent.
_____ 2. The person can be trusted.
_____ 3. The person has visions.
_____ 4. The person likes everyone.
_____ 5. The person is very even-tempered.
_____ 6. The person believes in God.
_____ 7. The person works well with others.
_____ 8. The person discusses all of his problems with others.
_____ 9. The person doesn't get along with others very well.
_____ 10. The person can communicate with the spirits of the dead.
_____ 11. The person seldom gets upset.
_____ 12. The person enjoys his or her family.
_____ 13. The person is loving.
_____ 14. The person does not smile.
_____ 15. The person seldom complains about anything.
_____ 16. The person makes decisions without consulting others.
_____ 17. The person doesn't think about other's needs much.
_____ 18. The person rarely believes his/her ideas are best.
_____ 19. The person has a professional career.
_____ 20. The person seldom tells the truth.
_____ 21. The person is seldom depressed.
_____ 22. The person hears things that others do not hear.
_____ 23. The person gets along with others.
_____ 24. The person is very religious.
_____ 25. The person's physical health is good.
_____ 26. The person thinks life has little meaning.
_____ 27. The person is cheerful.
_____ 28. The person feels that he/she has special powers to influence others.

1 = Very poor mental health
2 = Poor mental health
3 = Neutral, statement is not related to mental health
4 = Good mental health
5 = Very good mental health

_____ 29. The person shows consideration of others.
_____ 30. The person does not like to live alone.
_____ 31. The person is willing to help others.
_____ 32. The person believes him/her self to be an agent of God.
_____ 33. The person cannot be trusted.
_____ 34. The person feels that people can change drastically from day to day.
_____ 35. The person is poetic.
_____ 36. The person knows his or her own capabilities.
_____ 37. The person always keeps his or her cool.
_____ 38. The person does not believe in God.
_____ 39. The person is usually a leader.
_____ 40. The person had very high grades in school.
_____ 41. The person experiences the world differently from other people.
_____ 42. The person has had a lot of education.
_____ 43. The person treats others badly.
_____ 44. The person swears.
_____ 45. The person is not polite.
_____ 46. The person's life is very active.
_____ 47. The person is bored most of the time
_____ 48. The person likes to drink alcohol.
_____ 49. The person drinks a lot of alcohol.
_____ 50. The person is a hard worker.
_____ 51. The person says he or she doesn't have problems.
_____ 52. The person views other people pretty much as everyone else.
_____ 53. The person is open minded about other people's ideas.
_____ 54. The person has a working system of values.

1 = Very poor mental health
2 = Poor mental health
3 = Neutral, statement is not related to mental health
4 = Good mental health
5 = Very good mental health

_____ 55. The person does not act without advice from others.
_____ 56. The person thinks money is very important.
_____ 54. The person is friendly.
_____ 58. The person is pleasant.
_____ 59. The person comes from a stable family
_____ 60. The person is able to play.
_____ 61. The person is dependable.
_____ 62. The person distrusts everyone.
_____ 63. The person believes it is important to live near relatives.
_____ 64. The person is well-groomed.
_____ 65. The person views things differently at different times.
_____ 66. The person is able to love others.
_____ 67. The person believes life has meaning.
_____ 68. The person cares for others.
_____ 69. The person is reliable.
_____ 70. The person makes attempts to improve him or herself.
_____ 71. The person is able to forgive other people for their mistakes.
_____ 72. The person feels in control of things around him/her.
_____ 73. The person is not happy working at his or her job.
_____ 74. The person is physically active.
_____ 75. The person had average grades in school.
_____ 76. The person has confidence in himself (herself).
_____ 77. The person is not very religious.
_____ 78. The person does not dress very neatly.
_____ 79. The person sees things that others do not see.
_____ 80. The person's speech is easy to hear and understand.
_____ 81. The person accepts full responsibility for his or her own actions.

1 = Very poor mental health
2 = Poor mental health
3 = Neutral, statement is not related to mental health
4 = Good mental health
5 = Very good mental health

_____ 82. The person believes others know best.
_____ 83. The person is seldom fearful.
_____ 84. The person likes him or herself.
_____ 85. The person communicates directly and honestly with others.
_____ 86. The person likes to gossip.
_____ 87. The person likes to be with other people.
_____ 88. The person is in poor physical health.
_____ 89. The person seldom cries.
_____ 90. The person is very intelligent.
_____ 91. The person sees things as either right or wrong.
_____ 92. The person is frank and honest when stating beliefs and wishes.
_____ 93. The person is not a hard worker.
_____ 94. The person makes good use of his or her talents and abilities.
_____ 95. The person is honest.
_____ 96. The person is happy most of the time.
_____ 97. The person is not satisfied with himself or herself.
_____ 98. The person guides his life according to spirits.
_____ 99. The person seldom asks for assistance.

APPENDIX C

Sources of Referral Questionnaire

The following questions describe a possible situation in which someone you know is having a personal difficulty. In each instance, please indicate the degree to which you view it as a problem and how you would recommend that the person deal with the situation.

SITUATION #1

A couple you know is having serious relationship problems. They seldom communicate to one another without getting into a heated argument. They both blame each other for the failing relationship, and are feeling more and more concerned about their future together.

1) To what degree do you view this as a problem?

1 - not a problem at all
2 - a small problem
3 - a slightly difficult problem
4 - a difficult problem
5 - a severe problem

If you do view this as a problem, what would you suggest that this couple do?

For each option, please rate the likelihood that you would recommend that particular option, according to the following scale:

1 - highly unlikely, would never recommend this option for this situation

2 - somewhat likely, would recommend this option only as a last resort

3 - neutral, no opinion either way

4 - somewhat likely, would sometimes recommend this option

5 - highly likely, would always recommend this option for this situation

The options are:

2) _____ Discuss the problem with a religious/spiritual leader.

3) _____ Discuss the problem with a close friend.

4) _____ Discuss the problem with a doctor

5) _____ Work the problem out on their own.

6) _____ Discuss the problem with other family members.

7) _____ Discuss the problem with a mental health professional (psychologist, social worker, counselor, or psychiatrist).

8) _____ Discuss the problem with an older person whom you know

9)Do you view this as a mental health problem? Y (1) or N (2)

10)Has this situation occurred to anyone you know? Y (1) or N (2)

SITUATION #2

Someone you know is having difficulties with his/her child. The child is very resistant to discipline, and is always getting into trouble with teachers and classmates because of unruly behavior. The child does things impulsively without thinking of the consequences, and generally has no regard for the rights of others.

11) To what degree do you view this as a problem?

1 - not a problem at all
2 - a small problem
3 - a slightly difficult problem
4 - a difficult problem
5 - a severe problem

If you do view this as a problem, what would you suggest that this person do?

For each option, please rate the likelihood that you would recommend that particular option, according to the following rating scale.

1 - highly unlikely, would never recommend this option for this situation
2 - somewhat likely, would recommend this option only as a last resort
3 - neutral, no opinion either way
4 - somewhat likely, would sometimes recommend this option
5 - highly likely, would always recommend this option for this situation

The options are:

12) _____ Discuss the problem with a religious/spiritual leader.

13) _____ Discuss the problem with a close friend.

14) _____ Discuss the problem with a doctor

15) _____ Work the problem out on his/her own.

16) _____ Discuss the problem with other family members.

17) _____ Discuss the problem with a mental health professional (psychologist, social worker, counselor, or psychiatrist).

18) _____ Discuss the problem with an older person whom you know

19) Do you view this as a mental health problem? Y (1) or N (2)

20) Has this situation occurred to anyone you know? Y (1) or N (2)

SITUATION #3

Someone you know is feeling deep personal distress, for no apparent reason. This person looks depressed, and seems to be anxious, irritable, and "on edge" much of the time. This behavior is not like his/her normal way of behaving.

21) To what degree do you view this as a problem?

1 - not a problem at all
2 - a small problem
3 - a slightly difficult problem
4 - a difficult problem
5 - a severe problem

If you do view this as a problem, what would you suggest that this person do?

For each option, please rate the likelihood that you would recommend that particular option, according to the rating scale.

1 - highly unlikely, would never recommend this option for this situation
2 - somewhat likely, would recommend this option only as a last resort

3 - neutral, no opinion either way
4 - somewhat likely, would sometimes recommend this option
5 - highly likely, would always recommend this option for this situation

The options are:

22) _____ Discuss the problem with a religious/spiritual leader.

23) _____ Discuss the problem with a close friend.

24) _____ Discuss the problem with a doctor

25) _____ Work the problem out on his/her own.

26) _____ Discuss the problem with other family members.

27) _____ Discuss the problem with a mental health professional (psychologist, social worker, counselor, or psychiatrist).

28) _____ Discuss the problem with an older person whom you know

29) Do you view this as a mental health problem? Y (1) or N (2)

30) Has this situation occurred to anyone you know? Y (1) or N (2)

SITUATION #4

Someone you know is claiming to hear voices which no one else can hear. He/she states that the voices speak to him/her when watching T.V. or listening to the radio. The voices swear and harshly criticize the person for being worthless, and are very upsetting.

31) To what degree do you view this as a problem?

1 - not a problem at all
2 - a small problem
3 - a slightly difficult problem

4 - a difficult problem
5 - a severe problem

<u>If you do view this as a problem, what would you suggest that this person do?</u>

For each option, please rate the likelihood that you would recommend that particular option, according to the following rating scale.

1 - highly unlikely, would never recommend this option for this situation
2 - somewhat likely, would recommend this option only as a last resort
3 - neutral, no opinion either way
4 - somewhat likely, would sometimes recommend this option
5 - highly likely, would always recommend this option for this situation

The options are:

32) _____ Discuss the problem with a religious/spiritual leader.

33) _____ Discuss the problem with a close friend.

34) _____ Discuss the problem with a doctor

35) _____ Work the problem out on his/her own.

36) _____ Discuss the problem with other family members.

37) _____ Discuss the problem with a mental health professional (psychologist, social worker, counselor, or psychiatrist).

38) _____ Discuss the problem with an older person whom you know

39) Do you view this as a mental health problem? Y (1) or N (2)

40) Has this situation occurred to anyone you know? Y (1) or N (2)

SITUATION #5

Someone you know has recently had a close relative die. This person has been feeling anxious and upset and has been experiencing difficulty concentrating and sleeping. This person has also become less motivated to do things with other people and has become withdrawn.

41) To what degree do you view this as a problem?

1 - not a problem at all
2 - a small problem
3 - a slightly difficult problem
4 - a difficult problem
5 - a severe problem

If you do view this as a problem, what would you suggest that this person do?

For each option, please rate the likelihood that you would recommend that particular option, according to the following scale.

1 - highly unlikely, would never recommend this option for this situation
2 - somewhat likely, would recommend this option only as a last resort
3 - neutral, no opinion either way
4 - somewhat likely, would sometimes recommend this option
5 - highly likely, would always recommend this option for this situation

The options are:

42) _____ Discuss the problem with a religious/spiritual leader.

43) _____ Discuss the problem with a close friend.

44) _____ Discuss the problem with a doctor

45) _____ Work the problem out on his/her own.

46) _____ Discuss the problem with other family members.

47) _____ Discuss the problem with a mental health professional (psychologist, social worker, counselor, or psychiatrist).

48) _____ Discuss the problem with an older person whom you know

49) Do you view this as a mental health problem? Y (1) or N (2)

50) Has this situation occurred to anyone you know? Y (1) or N (2)

SITUATION #6

Someone you know has been hearing voices at night and has been having dreams of old people talking to him/her.

51) To what degree do you view this as a problem?

1 - not a problem at all
2 - a small problem
3 - a slightly difficult problem
4 - a difficult problem
5 - a severe problem

If you do view this as a problem, what would you suggest that this person do?

For each option, please rate the likelihood that you would recommend that particular option, according to the following rating scale.

1 - highly unlikely, would never recommend this option for this situation
2 - somewhat likely, would recommend this option only as a last resort
3 - neutral, no opinion either way
4 - somewhat likely, would sometimes recommend this option
5 - highly likely, would always recommend this option for this situation

The options are:

52) _____ Discuss the problem with a religious/spiritual leader.

53) _____ Discuss the problem with a close friend.

54) _____ Discuss the problem with a doctor

55) _____ Work the problem out on his/her own.

56) _____ Discuss the problem with other family members.

57) _____ Discuss the problem with a mental health professional (psychologist, social worker, counselor, or psychiatrist).

58) _____ Discuss the problem with an older person whom you know

59) Do you view this as a mental health problem? Y (1) or N (2)

60) Has this situation occurred to anyone you know? Y (1) or N (2)

SITUATION #7

An adult male, whom you know, has been drinking more and more and has been drunk more frequently. While he is drunk he becomes violent, gets into fights, destroys property, and occasionally hits his wife.

61) To what degree do you view this as a problem?

1 - not a problem at all
2 - a small problem
3 - a slightly difficult problem
4 - a difficult problem
5 - a severe problem

If you do view this as a problem, what would you suggest that this person do?

For each option, please rate the likelihood that you would recommend that particular option, according to the following rating scale.

1 - highly unlikely, would never recommend this option for this situation
2 - somewhat likely, would recommend this option only as a last resort
3 - neutral, no opinion either way
4 - somewhat likely, would sometimes recommend this option
5 - highly likely, would always recommend this option for this situation

The options are:

62) _____ Discuss the problem with a religious/spiritual leader.

63) _____ Discuss the problem with a close friend.

64) _____ Discuss the problem with a doctor

65) _____ Work the problem out on his/her own.

66) _____ Discuss the problem with other family members.

67) _____ Discuss the problem with a mental health professional (psychologist, social worker, counselor, or psychiatrist).

68) _____ Discuss the problem with an older person whom you know

69) Do you view this as a mental health problem? Y (1) or N (2)

70) Has this situation occurred to anyone you know? Y (1) or N (2)

SITUATION #8

Someone whom you know has been having stomach pains, dizziness, blurred vision, and headaches

71) To what degree do you view this as a problem?

1 - not a problem at all
2 - a small problem
3 - a slightly difficult problem
4 - a difficult problem
5 - a severe problem

If you do view this as a problem, what would you suggest that this person do?

For each option, please rate the likelihood that you would recommend that particular option, according to the following rating scale.

1 - highly unlikely, would never recommend this option for this situation

2 - somewhat likely, would recommend this option only as a last resort

3 - neutral, no opinion either way

4 - somewhat likely, would sometimes recommend this option

5 - highly likely, would always recommend this option for this situation

The options are:

72) _____ Discuss the problem with a religious/spiritual leader.

73) _____ Discuss the problem with a close friend.

74) _____ Discuss the problem with a doctor

75) _____ Work the problem out on his/her own.

76) _____ Discuss the problem with other family members.

77) _____ Discuss the problem with a mental health professional (psychologist, social worker, counselor, or psychiatrist).

78) _____ Discuss the problem with an older person whom you know

79) Do you view this as a mental health problem? Y (1) or N (2)

80) Has this situation occurred to anyone you know? Y (1) or N (2)

SITUATION # 9

A person whom you know has a friend who has recently begun acting rude and unfriendly towards this person. This friend has also been saying things about this person that are not true to other people.

81) To what degree do you view this as a problem?

1 - not a problem at all
2 - a small problem
3 - a slightly difficult problem
4 - a difficult problem
5 - a severe problem

If you do view this as a problem, what would you suggest that this person do?

For each option, please rate the likelihood that you would recommend that particular option, according to the following rating scale.

1 - highly unlikely, would never recommend this option for this situation
2 - somewhat likely, would recommend this option only as a last resort
3 - neutral, no opinion either way
4 - somewhat likely, would sometimes recommend this option
5 - highly likely, would always recommend this option for this situation

The options are:

82) _____ Discuss the problem with a religious/spiritual leader.

83) _____ Discuss the problem with a close friend.

84) _____ Discuss the problem with a doctor

85) _____ Work the problem out on his/her own.

86) _____ Discuss the problem with other family members.

87) _____ Discuss the problem with a mental health professional (psychologist, social worker, counselor, or psychiatrist).

88) _____ Discuss the problem with an older person whom you know

89) Do you view this as a mental health problem? Y (1) or N (2)

90) Has this situation occurred to anyone you know? Y (1) or N (2)

APPENDIX D

CONSENT FORM

The present study, "An Examination of the Mental Health Values of Native American College Students on three Reservations: A Comparative Study" is being conducted by Raymond List, a graduate student from the University of North Dakota Psychology Department. This study will ask for your views concerning healthy living and different problem situations. We want to examine how people differ in their perceptions of healthy living and possible problem situations. No names will be used for identifying questionnaires and your responses will be kept strictly confidential. There are three different questionnaires in this handout and it will take between 35 and 45 minutes to complete all three of the questionnaires. If you decide to participate, you are free to discontinue participation at any time without penalty. In return for full participation, you will be eligible to win either one of three $20 certificates for the local grocery store or one of five free meal certificates at the local restaurant. If you have any questions concerning this study, you may contact Raymond List through either writing or calling the following:

P.O. Box 987
Lame Deer, MT 59043
(406) 477-8367

By signing below, you are stating that you have read and understood the information in this consent form, including your rights as a participant. Signing you name does not obligate you to participate in the study. Thank you for your cooperation.

_____ _____

Participant's signature Date

APPENDIX E

PURPOSE AND DESCRIPTION OF AN EXAMINATION OF THE MENTAL HEALTH VALUES OF NATIVE AMERICAN COLLEGE STUDENTS ON THREE RESERVATIONS: A COMPARATIVE STUDY

The field of psychology and mental health have been seeking to increase their understanding of the Native American culture through research into the values and beliefs that shape the people's perceptions of life. The increased awareness that results from this research will help mental health professionals develop mental health programs that are more sensitive to each community's traditions and values.

The purpose of this study is to add to this research by examining how cultural and tribal differences, as well as differences in traditional orientation, influence mental health values and perceptions of common life situations. This study will be conducted with a group of Caucasian college students, as well as Native American college students from three different tribes. A few background questions related to spiritual orientation, level of education and tribal affiliation will be asked to help with the comparisons between the groups.

Mental health values refer to the attitudes and behaviors that people believe are most important in developing a healthy life. This

concept will be measured in this study with the Mental Health Values Questionnaire, which consists of descriptions of daily attitudes and behaviors. You will be asked to rate each description on how it relates to mental health.

The perceptions of common life situations will be measured with the Sources of Referral Questionnaire, which consists of nine descriptions of daily life situations. For each situation you will be asked to indicate the degree to which you view it as a problem and to evaluate the different sources of help for the situation.

REFERENCES

Attneave, C. L. (1969). Therapy in tribal settings and urban network intervention. Family Process, 8, 192-210.

Bearcomesout, H. (1993). personal communication

Bergin, A. & Jensen, J. (1990). Religiosity of psychotherapists: A national survey. Psychotherapy, 27(1), 3-7.

Bopp, M. (1987). Four worlds development project. Lethbridge: University of Lethbridge.

Brant, C. (1990). Native ethics and rules of behavior. Canadian Journal of Psychiatry,35, 534-539.

Brislin, R. (1980). Introduction to social psychology. In H.C. Triandis & R. W. Brislin (Eds.), Handbook of cross-cultural psychology (pp. 389-444). Boston: Allyn and Bacon.

Chance, N. (1962). Conceptual and methodological problems in cross-cultural health research. American Journal of Public Health, 52(3), 410-417

Fahey, J. (1974). The Flathead Indians. University of Oklahoma Press, Norman.

Grinnel, G. (1972). The Cheyenne Indians; Their history and ways of life, vol. II. University of Nebraska Press, Lincoln.

Guilmet, G, Whited, D, Hunter, W, Bloom, J, Levy, J, Neligh, G, Trimble, J, Manson, S, Mohutt, G, & Walker, R. (1988). Mental health in a general health care system. American Indian and Alaska Native Mental Health Research Monograph #1, 290-324.

Guilmet, G & Whited, D. (1987). Cultural lessons for clinical mental health practice: The Puyallup tribal community. American Indian and Alaska Native Mental Health Research, 1(2), 32-49.

Heinrich, R., Corbine,J, & Thomas, K. (1990). Counseling Native Americans. Journal of Counseling and Development,69, 128-133.

Honigmann, J. (1978). The personal approach in culture and personality research. In G.D. Spindler (Ed.), The making of psychological anthropology (pp.302-329). Los Angeles, University of California Press.

Hyde, G. (1959). Indians of the High Plains: From the prehistoric period to the coming of the Europeans. University of Oklahoma Press, Norman.

Jenness, D. (1959). The people of twilight. Chicago: University of Chicago Press.

Jensen, J. & Bergin, A. (1988). Mental health values of professional therapists: A national interdisciplinary survey. Professional Psychology: Research and Practice, 19(3), 290-297.

Jilek, W. (1974). Indian healing power: Indigenous therapeutic preactices in the Pacific Northwest. Psychiatric Annals, 4(9), 13-21.

Johnson, D., & Johnson, C. (1965). Totally discouraged: A depression syndrome of the Dakota Sioux. Transcultural Psychiatric Research, 1, 141-143.

Kealey, K. (1990). Cross-cultural effectiveness. Hull, QC, Canada: Canadian International Development Agency.

Kiev, A. (1972). Transcultural psychiatry. New York: Free Press.

LaBarre, W. (1964). Confession as cathartic therapy in American Indian tribes. In A. Keiv (Ed.), Magic, faith, and healing: Studies in primitive psychiatry today (pp. 36049). New York: Free Press.

Lafromboise, T, & Plake, B. (1984). A model for the systematic review of mental health research: American Indian family, a case in point. White Cloud Journal, 3(3), 44-51.

LaFromboise, T. (1988). American Indian mental health policy. American Psychologist, 43(5), 388-397.

Leff, J. (1979)). The cross-cultural study of emotions. Culture, Medicine, and Psychiatry, 3, 111-151.

Malach, R. & Segel, N. (1990). Perspectives on Health Care Delivery Systems for American Indian Families. Children's Health Care, 19(4), 219-228.

Manson, S. (in press) Physicians and American Indian healers: Issues and constraints in collaborative health care. In M. Beiser (Ed.), The Healing Arts (pp. 1-25).

Marano, L. (1982). Windigo psychosis: The anatomy of an emic/etic confusion. Current Anthropology, 23, 385-412.

Martin, M. (1981). Native American medicine: Thoughts for the posttraditional healer. Journal of the American Medical Association, 245(2), 141-143.

McDonald,D. (1991). Northern Plains American Indian mental health clients' therapist preference variables. unpublished document.

Miller, S. & Shoenfeld, L. (1971). Grief in the Navajo: Psychodynamics and culture. Paper presented at the Annual Meeting of the American Psychiatric Association, Washington,DC.

Minton, B & Soule, S. (1990). Two Eskimo villages assess mental health strengths and needs. American Indian and Alaska Native Mental Health Research, 4(2), 7-24.

Mosteller, F. & Tuke, F. (1977). Data analysis and regression. Addison Wesly; Reading, MA.

Nelson, S, McCoy, G, Stetter, M, & Vanderwagen, W. (1992). An overview of mental health services for American Indians and Alaska Natives in the 1990s. Hospital and Community Psychiatry, 43(3), 257-261.

Novakovsky, S. (1924). Arctic or Siberian hysteria as a reflex of the geographic environment. Ecology, 5, 113.

Parker, S. (1960). The wittiko psychosis in the context of Ojibwa personality and culture. American Anthropologist, 62, 603-623.

Piasecki, J, Manson, S, Biernoff, M, Hiat, A, Taylor, S, & Bechtold, D. (1989). Abuse and neglect of American Indian Children: Findings from a survey of federal providers. American Indian and Alaska Native Mental Health Research, 3(2), 43-62.

Pollack, D., & Shore, J. (1980). Validity of the MMPI with Native Americans. American Journal of Psychiatry, 137, 946-950.

Primeaux, M. (1977). Caring for the American Indian Patient. American Journal of Nursing, 91-94.

Putsch, R. (1988). Ghost illness: A cross cultural experience with the expression of a non-Western tradition in clinical practice. American Indian and Alaska Native Mental Health Research, 2(2), 6-26.

Red Horse, J. (1982). Clinical strategies for American Indian families in crisis. Urban and Social Change Review, 15(2), 17-19

Religion in America. (1985). Princeton, N.J.: The Gallup Report. Report No 236.

Shore, J. & Manson, S. (1981). Cross-cultural studies of depression among American Indians and Alaska Natives. White Cloud Journal, 2(2), 5-12.

Spaulding, J. & Balch, P. (1985). Perceptions of mental disorder of Yaqui Indians of Arizona: An initial investigation. White Cloud Journal, 3(4), 19-26.

Star, S. (1955). The public's ideas about mental illness. Paper presented at Annual Meeting of the National Association for Mental Health, Indianapolis.

Suan, L. (1989). Mental health value differences between Caucasian and Japanese-American Students. Unpublished master's thesis, University of North Dakota.

Sue,D, & Sue, D. (1990) Counseling the Culturally Different: Theory and Practice, 2nd ed. New York: Wiley.

Teicher, M. (1960). Windigo psychosis: A study of a relationship between belief and behavior among the Indians of Northeastern Canada. In V. F. Ray (Ed.), Proceedings of the 1960 Annual Spring Meeting of the American Ethnological Society. Seattle: University of Washington Press.

Trimble, J., & Lee, D. (1981). Counseling with American Indians: A review of the literature with methodoligical considerations. Paper presented at the American Educational Research Association, Los Angeles.

Trimble, J., Manson, S., Dinges, N., & Medicine, B. (1984) American Indian concepts of mental health: Reflections and directions. In P. Pedersen, N. Sartorius, A. Marsella (Eds.), Mental health services: The cross-cultural context, (pp. 199-120). Beverly Hills, CA: Sage.

Tyler, J.D., & Suan, L.V. (1990) Mental health values differences between Native American and Caucasian American college students. Journal of Rural Community Psychology, 11(2), 17-29.

Wallace, A. (1961). Mental illness, biology, and culture. In F.L.K. Hsu (Ed.), Psychological anthropology: Approaches to culture and personality (pp. 225-295). Homewood, IL: Dorsey.

Weyer, E. (1932). The Eskimos. New Haven, CT: Yale University Press.

Yates, A. (1987). Current status and future directions of research on the American Indian Child. American Journal of Psychiatry, 144(9), 1135-1142.